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Cancer and its Treatment

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Few persons ever stop to realise what a wonderful mechanism is that which controls the growth and repair of tissue in the human body. This mechanism it is which determines for example that when the body is cut or injured so that tissue is lost, new tissue is produced to make up for this loss *and no more;* that as the various tissues wear out, new cells are developed to replace them, just enough cells for the purpose *and no more;* thus the body is able to carry on its duties and make its own repairs throughout the long years of life in a truly marvellous manner. All of these changes are subject to the mechanism which controls the building up and breaking down of cells so that a very exact balance is maintained. Under certain conditions, however, some cells commence to grow independently of this mechanism so that the rate of growth of these cells is out of all proportion to the needs of the body *and is beyond the control of the body.* Such an overgrowth of cells is what is commonly referred to as "cancer" and it is capable by its overgrowth or by invasion of other tissues and dissemination to distant parts of the body of ultimately destroying the individual.

Viewed with the microscope a section of normal tissue may be compared somewhat to a section of honeycomb in which each cell is complete in itself and has definite boundaries which it recognises and adheres to closely. Cancer tissue, on the other hand, while composed of similar cells recognises no such boundaries, but invades the surrounding tissues regardless of whether these are muscles, fascial planes or even bone itself. Thus, the two outstanding characteristics of cancer cells are: first, their property of invasion of surrounding tissues and, secondly, their property of dissemination to remote parts of the body. When these cells become so disseminated they immediately commence to grow and produce in this new spot a growth very similar in its make-up and other characteristics to the parent from which the cells originally came. Such a growth is then known as a "secondary" cancer.

Varieties of Cancer

For the purpose of our present discussion it is sufficient to recognise two great groups or varieties of cancer: (1) Carcinoma, which is a cancer cell originating in epithelium, i.e., skin or mucous membrane, covering structures of the body; (2) Sarcoma. Of these there are several subdivisions as there are of carcinoma, but it is sufficient to say that sarcoma is a malignant growth originating in the connective or supporting tissues of the body.

What Do We Know of The Causes of Cancer?

While we know a very great deal about the varieties of cancer, its habits of growth, and life history, we do not know the specific cause, or what it is which starts this overgrowth in the first place. *First*, cancer never develops in perfectly health tissue. There is always some abnormality present and this is frequently present for a very considerable length of time before the cells definitely change from simple unhealthy cells to definitely malignant ones. *Second*, in the beginning cancer is always a local disease; in some parts of the body this is very easy to observe and verify. In some organs it is more difficult to verify, and yet, all the available information confirms the statement just made.

(An address delivered to the Association of Registered Graduate Nurses of Ontario, June 15, 1931.)

We now have a considerable accumulation of information regarding some varieties of cancer tending to show that irritants play an extremely important part in its production:

(1) *Heat*: A good illustration of the manner in which heat can act as an irritant ultimately leading to the formation of cancer is found in certain people in the mountains of India. In these regions the cold is very intense and the people are in the habit of carrying a small basket containing live coals of charcoal against the abdomen inside their sheep-skin coats. These are worn over long periods of time and ultimately a considerable number of these people develop cancer of the skin of the abdomen directly at the point where the heat has been present over a long time.

(2) *Cold*: In this country we frequently make the observation and a similar one has been made amongst the sailors of the North Sea, that epithelioma develops along the skin of the ear in the site of frost bites.

(3) *Chemical Causes*: One of the classical illustrations is the development of cancer of the skin in chimney sweeps in England, due to the irritation from the soot to which they are exposed. Similar cancers occur in those who are exposed to various kinds of tar in manufacturing processes and in certain oils in the spinning of wool. An extremely interesting example occurs in the aniline dye factories in Germany. Workers who are exposed for a number of years to the aniline dyes in these factories frequently develop cancer of the bladder and this has been noted in many cases even years after the workers had left the factory. The percentage of cases is so high as to be definitely recognised as having a connection with the aniline dye industry.

(4) *X-rays, Radium and Sunlight*: These are three forms of energy which differ from each other only in wavelength and all are capable of causing cancer of the skin by long continued exposure. In many parts of the world rodent ulcers and epithelioma of the skin are very common in individuals who are exposed to the irritating effects of sunlight for very long periods of time. This is particularly true in Australia, especially with fair-haired individuals. In connection with x-rays and radium, many of the early workers have paid with their lives and this danger is now well known and should be adequately guarded against. It is the long continued exposure to small amounts of both of these such as occurs in the fingers of those who are called upon to work with them. There is no danger under proper conditions to patients undergoing treatment.

(5) *Septic Teeth, Tobacco, etc*: It is extremely rare to see a cancer in the oral cavity in an individual who has healthy teeth and a clean mouth. Cancer in the oral cavity commonly develops in some location where the tissues are being constantly damaged by a jagged tooth, an ill-fitting plate or are being irritated by dirty septic teeth or the effect of tobacco or syphilis.

(6) *Trauma*: There seems to be undoubtedly a relationship between trauma and cancer, although this must be extremely rare since all of us are constantly receiving small injuries which might otherwise result in cancer with disastrous results to the human race.

Most other theories of the cause of cancer are more or less speculative and it is along this line that the most intensive research is being conducted at the present time. It is quite possible that the cause of cancer may prove to be multiple and differ for different forms of cancer in different organs of the body. And without any thought of discouraging the intensive research which is being carried out, it is only right that we should realise the fact that the discovery of the cause of cancer might not lead immediately nor even directly to any certain cure for the disease. The discovery of the cause of tuberculosis did not lead

immediately to a discovery of its specific cure and the progress which has taken place in this disease has had little benefit from the knowledge of its cause, whereas, this knowledge has benefited immensely along lines of prevention, and the protection of others from those afflicted with the disease.

Is Cancer Contagious?

There is absolutely no evidence to indicate that cancer is contagious or infectious, or in fact that it is transmissible from one individual to another and this is a fact which should be emphasized by the nursing profession to the public in every way possible.

Is Cancer Increasing and What Is To Be Done About It?

Undoubtedly cancer is increasing. Statistics show that it has increased from 25 to 40 per cent. in the last twenty years. There are many ways of explaining this, but it seems better frankly to admit the fact that the disease has increased and should be regarded as a definite menace in every community. It is probably not far from the truth to say that 10 per cent. of deaths in adult males and 15 per cent. in adult females are due to cancer. If this is so, what is being done, or what more can be done to meet the situation?

If, as we have stated, we do not know the cause of cancer, and if it is neither contagious nor infectious, how then may we hope to accomplish anything along the line of prevention? There is probably no field in which the nursing profession can be of greater value than in this very field of activity. Since cancer in its early stages is localised, and can be cured in a high percentage of cases by eradicating this localised growth, it is scarcely possible to over-emphasize the benefits which may follow from the dissemination of this knowledge and prompt action along this line. This involves the early recognition and adequate treatment of all precancerous lesions. There are a number of organs in the body in which this is beyond our reach, but the following indicates those in which it is very easily within our reach and in which much may be accomplished in the way of prophylaxis.

(1) *The Skin*: Warts, moles and keratoses generally should be regarded with suspicion from middle life onwards and should be recognised as pre-cancerous lesions and dealt with accordingly. If they give evidence of increasing in size, becoming irritable or otherwise changing their character they should be treated at once. Black or pigmented moles are especially dangerous and should be eradicated either by wide excision or by electrical destruction followed by radium treatment.

(2) *The Lip and Mouth*: On the lip any crack or fissure, keratosis, fever blister, or superficial ulcer which does not respond to simple treatment and heal in a comparatively short time, should be regarded as a potential cancerous lesion and treated accordingly. At this stage not less than 95 per cent. and usually 100 per cent. of these lesions can be permanently cured, and if this were done none of them would be allowed to develop into true cancers. Even though a few did develop if they are accurately recognised as malignant lesions, the majority could still be cured either by excision or by radium or x-ray treatment.

(3) *Lumps in the Breast*: Many women with a lump in the breast fail to report to their doctor because of the fear that he will advise an operation. It should be emphasized to the public that an operation should only be a thing to be feared if done too late. If the public knew the following facts it would probably do much to remove this fear. Operation for cancer of the breast, if the disease is limited to the breast, succeeds in more than 70 per cent. of the cases in completely curing the patient. At this stage there is nothing to fear, but if the disease is neglected until it spreads beyond the breast, the per-

centage of cures falls off very rapidly and is certainly not greater than from 20 per cent. to 30 per cent. Patients should be urged to report at once the discovery of a lump in the breast or of a blood stained discharge from the nipple. They should be informed that cancer is only painful in its later stages and that therefore, because a lump is not painful is no reason for considering it of no importance.

(4) *Lacerations of the Cervix*: This is perhaps more directly the province of the family physician but the nursing profession can do much by encouraging women in general to have lacerations of the cervix repaired and cervical diseases removed, particularly after the child-bearing period has been passed.

(5) *Bodily Hygiene*: It is a mere truism to say that people neglect their bodies outrageously. Many people give less attention to their bodies than they do to animals who serve them or machines which work for them. The mouths of many people who report with carcinoma are simply filthy. If these were their backyards, the health authorities would have them cleaned up; but since they are personal properties, no outsider can interfere.

Constipation is another evidence of neglect of the body and it should be corrected, preferably by a proper selection of food, but in any case it should be corrected.

Thus, by a thorough system of cleanliness and care of the body, a very great deal can be accomplished in cancer prevention. Next to this comes early recognition of those slighter departures from the normal which are the border-line stages and which should be removed. Fads should be discouraged and the public should be informed, for example, that so far as we know there is no direct connection between any particular diet and the occurrence of cancer. Cancer occurs in those who eat meat and those who do not. It occurs in those who are civilised and those who are not. It occurs amongst the lower animals, such as dogs and wolves, whose diet is largely meat, and in rabbits whose diet is solely vegetarian. It occurs commonly among fish and is quite common among plants both in the wild state and in a state of cultivation.

Treatment

There are only a few agencies which are of value in the treatment of this disease and all sorts of experiments have been tried and have failed to bear the test of time. Among those which have failed up to the present are the various sera. "There is no drug or serum known which can cure cancer and anyone who claims secret knowledge or advertises such a cure should be regarded as a 'quack'." A few years ago much was expected from the use of colloidal lead but this has failed to stand the test of time. Caustic pastes have been used for generations as a remedy for cancer and in the superficial varieties of this disease in their time they had an important place. At the present time they are antiquated measures which are crude and not to be compared with the modern means of dealing with the disease. Of these there are only three, viz: first, surgery; second, cautery methods; third, x-ray and radium. Surgery has for many years been the sole method of dealing with cancer and still occupies the first place. Various cautery methods have their place in dealing with certain types of accessible lesions. X-ray and radium are newer and have made important progress in the past few years. They both have very definite indications and definite limitations which it is important to recognise, but both are progressing rapidly and from them much further improvement may be expected.

What May Be Expected in Treatment By Radium and X-ray?

(1) *Skin Lesions*: Almost 100 per cent. of skin cancers should be cured under present conditions. Failures now occur practically entirely in those cases which have been neglected until

they have extended deeply under the skin or have involved bone or cartilage, or which have been unsuccessfully treated by caustics or by x-rays or radium. It is extremely important in this as in most other cases of cancer that the first treatment should be successful. If it fails the tissues undergo changes which make subsequent treatment more difficult and may make a cure impossible.

(2) *The Oral Group*: Cancer of the lip in which no glands are involved should be cured in about 90 per cent. of the cases, but if the glands are involved at the time of treatment, the percentage of cures is much reduced and probably does not exceed 50 per cent.

Cancer of the Tongue: The results of treatment vary depending upon the location of the lesion in the tongue and also upon whether or not glands are affected. At the tip of tongue, cancers can be cured in about 40 per cent. to 50 per cent. of the cases, whereas at the base of the tongue the percentage of cures is between 10 per cent. and 15 per cent. In the tonsil the percentage is about 25 per cent., and on the back of the throat it is between 40 per cent. and 50 per cent. This location is slightly more favourable because it does not tend to become disseminated quite so early.

Progress is being made quite rapidly in this group of cancers, and with earlier recognition and more skilful treatment it may be expected to be greatly improved in the next ten years.

(3) *Cancer of the Uterus*: Here again everything depends upon early recognition and adequate treatment. The best figures show that the average curability of carcinoma of the cervix is about 50 per cent. if it is treated early and 17 per cent. or less if treatment is not undertaken until the disease is well advanced. In these days when frankness is considered a virtue, every woman should understand that bleeding between menstrual periods, or bleeding after the menstrual function has stopped, demands investigation, and she should not rest content until she has been thoroughly examined and the cause of the bleeding discovered.

(4) *Carcinoma of the Breast*: If the disease is recognised early and operated upon while it is still limited to the breast, about 70 per cent. of cures will be obtained. Under these circumstances there is little field for x-rays or radium, but if the disease has been neglected and allowed to extend beyond the breast into the glands of the axilla or elsewhere the percentage of cures by surgery alone drops to between 20 per cent. and 30 per cent., and here the use of x-rays following the operation is of the greatest possible value and has been the means of raising the percentage of cures on an average between 25 per cent. and 50 per cent., i.e., the addition of properly administered high voltage x-ray treatment following the operation increases the patient's chance for a cure not less than 25 per cent., and some writers even claim as high as 50 per cent.

Conclusions:

Those who are closest to the problem and are in a position to see both the successes and failures feel that there is increasing ground for hopefulness, in spite of the fact that figures indicate an increase in the rate of cancer. There is not the slightest doubt that our facilities for dealing with this terrible disease are more effective than they have ever been and are steadily being improved. Certainly more patients are being cured than ever before, and this is being accomplished with less mutilation and infinitely less suffering. The watchword of the medical and nursing professions should be "early, accurate diagnosis and prompt, efficient treatment." There is no place in this work for the amateur or the charlatan, both of whom have been altogether too prevalent in the past.

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Editorials

Courage and Optimism

The years 1930 and 1931 will go down in history as years marked by general economic depression and unemployment. To this will be added, in some parts of Canada, a record of unprecedented drouth and crop failure. From the distress and disruption consequent upon such conditions no part of the population can hope to be entirely exempt. Canadian nurses are today feeling the strain occasioned by the chaos of such world conditions.

It is not impossible to find records of previous periods of a similar nature of depression through which the nursing profession has passed, nor is it impossible to find records of the courageous spirit with which such periods have been faced. Happily, it does not appear to be our nature to dwell upon past difficulties. They are fairly readily forgotten. Depression of mind, too, quickly disappears when the first signs of returning prosperity are seen. Perhaps this thought may hold some cheer at this time!

The past decade has marked much progress in nursing. The education of the student nurse is becoming organised on a more accepted educational basis; graduate study is definitely provided in leading universities; public health work is growing steadily in both official and voluntary organisations, and, very important indeed, a growing knowledge of health needs, on the part of the people, has brought about a most insistent public demand for health service. True, the progress made is only a beginning and much hard work remains, pioneer work in many things, as we shall undoubtedly be informed by the Report of the Survey of Nursing in Canada. The Survey in itself indicates progress, since a desire to seek out faults and to correct them can only have come from a deep knowledge of the needs of nursing education and of the possibilities for service in nursing. Nurses in the next decade will have cause to thank the leaders of today whose insight, clear thinking and ability to follow thought with action have made the Survey possible.

Out of the progress in nursing in recent years ideals have gradually been formulated—ideals of service, ideals of organisation, ideals of qualification, and the standards which have been set up and which represent these ideals are quite definitely the outcome of knowledge and experience. Whatever the burden which present economic conditions may place upon us, there must be no suggestion that these standards and ideals should be lowered even in the slightest degree. To accept a lower standard even temporarily may be retrogression. To maintain standards and to cling persistently to ideals, while showing outwardly less advance, may be the finest type of progress. It requires courage, at least, and courage, J. M. Barrie says, is "the lovely virtue" and "comes all the way".

In many parts of Canada this year, nursing in all its branches is confronted with conditions which must inevitably retard for a time the expansion and development which have been indications of progress. With financial conditions as they are it is impossible that it should be otherwise. At the same time there is an equally inevitable increase in the need of the people for the service we can give, since poverty and destitution have always in their wake a never-ending line of physical ills. To secure more service for a needy people, with a much reduced budget from which to supply it, is the difficult task facing many nursing organisations today. How it will be done remains to be seen, but it must be admitted that all the ability, all the determination and all the faith of which administrators are capable will be required for the task. Of the outcome there can be no doubt. Canadian nurses will meet the situation successfully and with an unfailing spirit of optimism.— R.M.S.

Child Psychology and the Child-Parent Relationship

No greater opportunity is presented than that which comes to the community nurse, particularly to those in the public health group. I have reference to the child psychology and the child-parent relationship study, and speak as one, not in authority, but as a graduate nurse and mother, who has realised far-reaching results through having developed a better understanding between child and parent. Our children are the greatest heritage we possess, and many mothers, after becoming interested in study-groups and reading literature pertaining to child psychology, have remarked, "I never realised before what a privilege it was to mother a family. I had regarded it as a condition having been thrust upon me."

For a nurse to interest herself in this subject, sufficiently to radiate her influence among her contacts, an extensive course is not necessary. In the larger centres, where a course is available, one is fortunate indeed to avail oneself of the opportunity, and I would stress the point of studying child psychology, if for no other reason than in later years applying it to one's own children. Surely nothing is more important than the mental health of a child. Far too few parents realise that, during the first seven years, the child's life in their care is as pliable as putty—theirs to make or mar—maybe through only one of the many traits, viz., that of creating an inferiority complex, a handicap that increases with adult years, and that could easily have been avoided. If, as we are told by one poet, life is made worth while by helping one fallen robin back into its nest again, how much greater is our opportunity of preventing a child from leaving the home-fireside?

The public health nurse who has qualified to introduce this subject to an understanding mother can feel that she has accomplished her good deed for the day, for it is like the pebble cast into the ocean, with its ever-increasing circles.

The interested mother is not necessarily a university graduate. She acts as a leader, not in the capacity of an authority, to provide a prescription, as it were, but to encourage discussion, and through that medium to establish a principle that may be adopted in any household. It is so comforting to return home realising that one's child is not unusually naughty, merely normal, and one's problems are shared by others. One realises, as maybe never before, that however small the child, it also has a personality, possessing viewpoint which deserves interpretation.

The following quotation proved the means of convincing one mother to act as a group leader, and she said never again did she "shout" at her children, no matter how worried or flurried:

"THE TONE OF VOICE"

It is not so much what you say,
As the manner in which you say it;
It is not so much the language you use,
As the tone in which you convey it.
"Come here!" I sharply said,
And the baby cowered, and wept.
"Come here!" I cooed, and she looked and smiled,
And straight to my lap she crept.

Whether you know it or not, whether you mean or care,
Tenderness, kindness, love and truth, envy and anger are there.
So if you would quarrels avoid, and in peace and love rejoice,
Keep anger not only out of your words,
But keep it out of your voice.

M. E. H.

Windsor Special Treatment Clinic

By CORA APPERLEY, Social Service Nurse, Special Treatment Clinic, Windsor, Ont.

Previous to the war of 1914-1918, the problem of Venereal Disease control had received very little attention in Canada. However, conditions uncovered in the army made it imperative that some steps be taken. In 1917 the Ontario Government appointed a Royal Commission of Investigation, with the result that, in 1918, the Venereal Diseases Prevention Act was passed. The main provisions of this Act were:

Reporting of new cases by serial number;

Compulsory examination of (a) persons under arrest or in custody; (b) upon receipt of credible information;

Prescribing course of conduct, (a) sex conduct, (b) treatment;

Detention of infected persons;

Prohibition of treatment by unqualified persons;

Prohibition of advertisement of cure;

Requiring hospitals to provide facilities for treatment;

Enjoining secrecy on persons administrating Act.

The Local Medical Officer of Health is responsible for the enforcement of this Act.

The Federal Government voted a certain sum of money to be used to establish and carry on clinics throughout the provinces, the money to be divided according to population, on condition that a like amount be provided by the provinces. Ontario agreed to this, and at the present time there are eighteen clinics within the province. Windsor was chosen as the site of one clinic.

The Border Cities, situated on the shores of the Detroit River directly across the line from Detroit, is an automobile centre. It is comprised of six municipalities (Riverside, East Windsor, Walkerville, Windsor, Sandwich and Ojibway) each with its own municipal organisation except for union under a joint Board of Health. The total population is 112,109, of which approximately 12,500 are aliens. Predominating among the aliens are Russians, Poles, South-Eastern Europeans and Chinese. There is also a high percentage of transients, due to the fact that it is so close to a port of entry to the United States. Windsor, the largest of these municipalities, has a population of 68,079, and of these 6,910 are aliens. About 25% of the total population of the Border municipalities is French-Canadian, this being one of the earliest settlements when Canada belonged to France.

Windsor Special Treatment Clinic was opened in July of 1920, with Dr. A. L. Poisson as Medical Director. Dr. Poisson, a graduate of the Medical School of the University of Western Ontario of 1914, is a specialist in Urology, and spent three years during the war with the Canadian Army Medical Corps in England and France.

In June of 1921 a full-time graduate nurse was appointed. Her duties were to wait on the doctor, admit patients, and do the follow-up work. The staff at this time consisted of a doctor, nurse and an attendant.

The first site of the clinic was the third floor of a down-town office building, and consisted of four small rooms—a waiting-room accommodating about ten persons, an office and two small treatment rooms. During July, eight patients were treated, with a total of twenty-eight treatments given. In August, twenty-one patients and eighty treatments given. The clinic grew steadily, as can be seen from Charts Nos. 1 and 2. The rooms soon became too small to accommodate the patients coming, and in 1923 space was taken in another office building. A laboratory and irrigation room were added, and the waiting room and treatment rooms were much larger than before. At this time 249 active cases were being cared for and an

average of 500 treatments given per month. In 1924 the work became too heavy for one doctor, and an assistant was appointed (part time). More space was taken in 1926 and the rooms were again enlarged. Again in 1929 more space was taken, giving a floor space of 1,500 square feet. The cubicle system was installed at this time. At the present time there are 405 active cases listed and an average of between 80 and 90 treatments per clinic being given. Four clinics of two hours each are held per week. The hours are so arranged that the patient may come from work, get his treatment and go home without anyone knowing of his call. The clinic, situated always in an office building and never in hospital, is a help to the patient in keeping the knowledge of his infection a secret.

The staff now consists of two doctors (part time), two full-time nurses and one part-time nurse (all graduate nurses).

There is no fee for treatment received. The object of the clinic is to give the patients adequate treatment, and treatment until they are cured or pronounced non-infective by the physician in charge. Although no patient is refused treatment whether he can pay or cannot pay, at least 95% are not in a position to pay for sustained treatment.

Patients on admission are interviewed by the social service nurse, after which they are seen by the physician in charge. When the diagnosis is made, this history is taken. The patient is instructed with regard to his own health: his diet, the danger of alcoholic drinks, etc. He is advised as to the care he must take for the protection of others, such as using his own towels, drinking cups, and his conduct. A written copy of instructions for conduct while under treatment is given, with an explanation of the penalty for violation of these rules. As far as possible, all contacts of the patient as well as the source of infection are located and examined.

The waiting room has been made as attractive as the funds will allow, with plants, magazines, health posters, a lending library and a few pieces of wicker furniture. The name on the door of the waiting room reads: "Special Treatment Clinic," and this is as the clinic has always been known rather than a Venereal Disease Clinic.

In the Border Cities there are 120 medical practitioners. Of these, 25% have referred indigent cases to the Board of Health during 1929 and 1930, while 5% reported the defaulters. The term "defaulters" is used in connection with patients who have violated the Venereal Diseases Prevention Act.

Since the opening of the clinic many problems have arisen, some requiring the enforcement of the law, such as patients discontinuing treatment while still in an infectious condition, or patients found to be disobeying the instructions given them, etc. In many cases the former defaulters have been located through the Courts, as very often these people are law-breakers. We have always received splendid co-operation from the police magistrates and the police and immigration departments.

Many of the syphilis contacts are found in the patient's family, e.g. wife and children. In gonorrhoea the most of the cases are single men and young single girls.

In 1930 there were 91 persons examined who were found to be free from venereal disease at the time of examination.

TABLE No. 1

SHOWING SOURCES OF NEW CLINIC PATIENTS

	1928	1929	1930
Social Agencies	--	10	13
Patients (friends and family)	8	3	2
Came voluntarily	98	74	66
Referred by Physicians	45	41	34
Referred by Courts, Police, etc.	15	5	8
Referred by Hospitals and Institutions	5	--	1
TOTAL	171	133	124

These patients were referred to the clinic without having had any previous treatment.

TABLE No. 2

SHOWING ADULT ADMISSIONS TO CLINIC

	New Cases			Re-Admissions			Previously Treated Elsewhere		
	Gono.	Syph.	*D.I.	Gono.	Syph.	*D.I.	Gono.	Syph.	*D.I.
1928—TOTAL	101	47	16	14	14	2	11	18	2
Male	83	20	6	12	7	1	8	10	1
Female	18	27	10	2	7	1	3	8	1
1929—TOTAL	73	55	8	15	34	1	18	27	4
Male	56	36	3	11	26	0	11	15	2
Female	17	19	5	4	8	1	7	12	2
1930—TOTAL	87	29	7	39	30	1	37	39	4
Male	59	16	3	27	18	0	29	29	--
Female	28	13	4	12	12	1	8	10	4

*D.I.—Double Infection.

TABLE No. 3

SHOWING ADMISSIONS OF CHILDREN TO CLINIC

	New Cases		Re-Admissions		Previously Treated Elsewhere	
	Gono.	Syph.	Gono.	Syph.	Gono.	Syph.
1928—TOTAL	2	6	1	1	--	1
Male	--	2	--	--	--	--
Female	2	4	1	1	--	1
1929—TOTAL	3	2	1	1	2	--
Male	1	1	--	1	--	--
Female	2	1	1	--	2	--
1930—TOTAL	3	3	1	--	5	4
Male	1	2	--	--	1	4
Female	2	1	1	--	4	--

TABLE No. 4

SHOWING PATIENTS DISCHARGED DURING 1930.

	Gono.	Syph.	D.I.
Apparently cured: TOTAL	111	23	9
Men	83	16	3
Women	24	5	6
Children	4	2	--

TABLE No. 5

SHOWING PATIENTS LOST DURING 1930

	Gono.	Syph.	D.I.
TOTAL	15	24	1
Men	7	16	--
Women	6	6	1
Children	2	2	--

TABLE No. 6

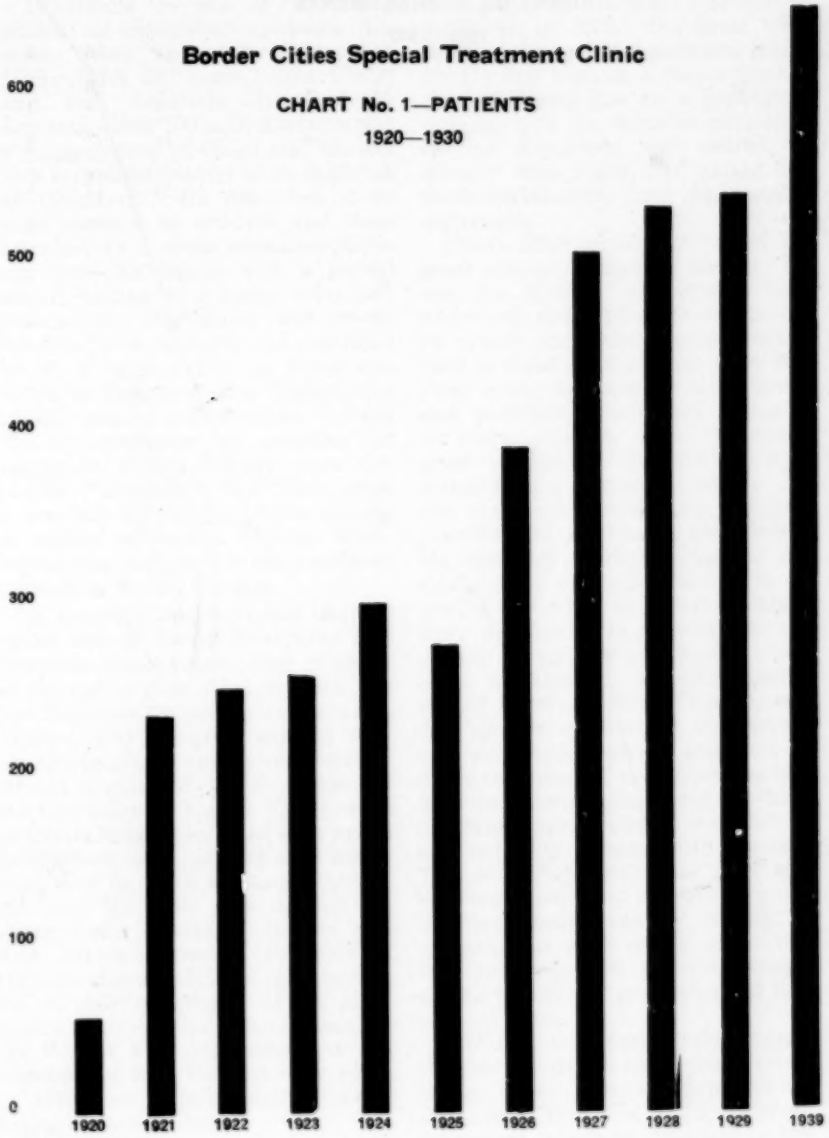
PATIENTS REFERRED FROM THE CLINIC TO PHYSICIANS, INSTITUTIONS, OR OTHER CLINICS FOR TREATMENT DURING 1930

	Gono.	Syph.	D.I.
TOTAL	32	59	15
Men	18	31	6
Women	12	27	9
Children	2	1	--

TABLE No. 7

SHOWING NUMBER OF CONTACTS LOCATED, EXAMINED, AND PLACED UNDER TREATMENT DURING 1930

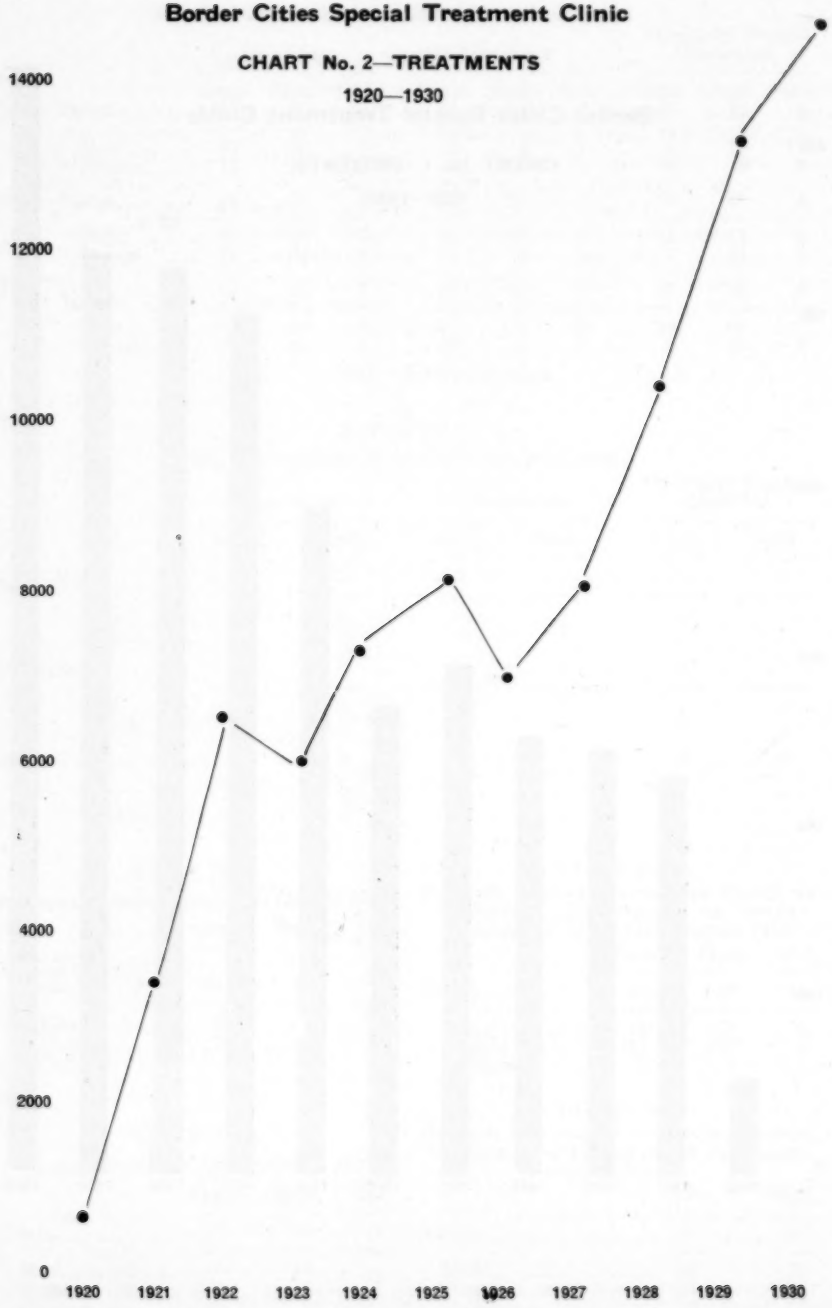
	Gono.	Syph.
TOTAL	74	26
Male	50	12
Female	22	11
Children	2	3


Border Cities Special Treatment Clinic
CHART No. 1—PATIENTS
1920—1930
600
500
400
300
200
100
0
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1939

Border Cities Special Treatment Clinic

CHART No. 2—TREATMENTS

1920—1930



The Story of Diphtheria

By H. B. CUSHING, M.D., Montreal.

Diphtheria is one of the most ancient of recognised epidemic diseases, being apparently known to Hippocrates 300 years before Christ and first definitely described by Aretaeus about 100 A.D. Aretaeus was a contemporary of Galen and has left us a very clear picture of an epidemic of diphtheria. He described it as more common in children and characterised by a moist substance forming over the tonsils with a putrid odour, leading to a husky voice and suffocation. Diphtheria was recognised early in America, and described by W. Douglas (1736) as a new epidemic in Kingston, near Boston, and called angina ulceuseulosa. Bard (1771), professor of practice of physic in King's College (now Columbia University), New York, gives a classical description of the disease as angina suffocativa. George Washington was supposed to have suffered from it at Mount Vernon.

In France, Napoleon Louis Charles, eldest son of Louis Bonaparte and Hortense Beauharnais, died of croup at the age of four years in 1807. He was Napoleon Bonaparte's godson and nephew, and the great general with his characteristic energy immediately offered a prize of 12,000 francs for the best essay on croup. This proved as sterile of real results as such prizes have always been; seventy-nine essays were sent in, none showing originality, and the prize was divided between Louis Jurine of Geneva and J. A. Albers of Bremen. Probably all the contestants published their essays, for in the first quarter of the nineteenth century over 100 treatises on the subject were published, but one searches in vain for any new ideas or even new facts of clinical observation well recorded.

The modern conception of diphtheria really dates from the classical monograph of Professor Bretonneau, published in 1826. His great work consists of a series of memoirs, giving for the first time an accurate description of diphtheria as a contagious disease, with its detailed pathology, diverse symptoms and course, its identity with croup, and giving it a name diphtheritis, from *diphthera*, a membrane.

Pierre Bretonneau was one of the great masters of medical history. He was the first to differentiate both diphtheria and typhoid fever. He was an ardent and indefatigable worker, used to make ward rounds in his hospital every morning at six o'clock, and personally performed autopsies on every available case. He was a great teacher in the clinical style rather than a lecturer or writer. He was not very popular with the local practitioners of Tours, who denied his teachings of diphtheria and the existence of any epidemic. It is recorded that when he failed to obtain their permission to demonstrate the disease by autopsy on some of their cases, he went out at night, accompanied by the faithful Velpeau, and dug up two or three of the corpses and performed hurried autopsies to prove they died of the disease he had described. Being discovered on these nocturnal expeditions, he was shot at and narrowly escaped with his life. This sort of thing did not make him any more popular, and for decades the local medical society refused to recognise his work or use his names for diphtheria and typhoid, though all the rest of the medical world had adopted them.

Probably the most interesting of the case reports in his great memoirs is the famous case of Elizabeth de Puysegur. This was a little girl of four years, whom he describes as the remaining daughter of his dearest friend, the Comte de Puysegur. The count had already lost three children by diphtheria, and when the remain-

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ing child threatened to suffocate like the others with laryngeal involvement, Bretonneau saved her life by the first recorded successful tracheotomy in diphtheria. As one reads the detailed case report one wonders how she happened to recover, for Bretonneau started treatment with an emetic, then cauterized the throat with concentrated hydrochloric acid, then ordered two grains of calomel every two hours, with occasional doses of jalap and castor oil. He afterwards increased the calomel to every hour. He performed the operation on the sixth day, having postponed it until the last possible moment, and used a tube of his own devising. He blew more calomel down the tube at frequent intervals, but found this caked and blocked it. She expelled casts of the trachea and bronchi through the wound, but eventually recovered and later married and became rather a famous personage, the Comtesse de Billy.

Although Bretonneau's work was far in advance of anything previous, there are naturally many errors and omissions in it. He confused ulcerative stomatitis with diphtheria and did not recognise the effect on the heart or post-diphtheritic paralysis, etc., yet for the first time he established the disease as a recognisable entity.

After Bretonneau comes a long period of confusion: the first stage of recognition and definition of the disease was reached, but so long as there was no exact knowledge of the cause or accurate means of diagnosis there was constant controversy. Thus we find Bretonneau's great pupil, Trousseau, trying to distinguish diphtheria and croup as separate diseases, although he added items to our knowledge, especially about the effects of diphtheria on the nervous system and the heart. He changed the name diphtheritis to diphtheria. Even the great Virchow, the father of pathology, published an able article in 1847 to prove that diphtheria and croup were two different processes, chiefly because the membranes in the trachea and bronchi were always loose and caused no necrosis of the underlying mucosa.

Not only was there confusion as to what was included under the specific disease, but also as to the manner of its spread and whether it was infectious or not. Thus we find many trying to reproduce false membranes by artificial means, such as irritant substances. Bretonneau himself, although convinced it was contagious, confesses that his attempts to induce the disease in animals were negative. Trousseau and Michel Peter, who succeeded him, both tried to inoculate themselves on the arms and on the tonsils with pieces of false membrane, but unsuccessfully, presumably being immune like most adults.

The third period comprises the discovery of the organism causing diphtheria and the study of its peculiarities and effects on animals and man, at last affording us an accurate scientific knowledge of the disease and a test for diagnosis. It is interesting that all these further advances were made not by practising physicians, but by scientists devoting their whole time to research. They were chiefly inspired by and worked in the institutes founded by Koch in Germany, and Louis Pasteur in France. The actual discovery of the diphtheria bacillus was made by Professor Edwin Klebs in 1875. He was one of the earlier assistants of Virchow and credited with many bacteriological advances. He demonstrated the organisms in sections of the false membranes, but did not grow them or produce the disease by their means. Many other organisms had been described previously as the cause of the disease, cocci, fungi, organisms in the blood, etc., so Klebs' announcement did not attract much attention at the time. Friedrich Loeffer (1852 to 1915), an assistant of Professor Koch, issued in 1884 his exhaustive and epoch-making work on the diphtheria bacillus. It is one of the classics of bacteriological science and a triumph

for the doctrines and technique laid down by Robert Koch. He grew the organisms on his own medium, stained them by his own preparation of methylene blue, inoculated them in animals, and showed how cultures might be used for the identification of the disease. Loeffer's work was almost immediately confirmed and the differentiation of the disease and the manner of its transmission established.

The next great advance in the treatment of diphtheria was the introduction of intubation in 1888. This life-saving operation we owe entirely to the genius and painstaking industry of Dr. Joseph O'Dwyer, of New York City. Dr. O'Dwyer (1841-1898) was born in Cleveland, Ohio, spent his boyhood and was educated in Ontario, near London, and afterwards went to New York for his medical education. In 1872 he started practice in New York and was appointed to the staff of the New York Foundling Hospital, where he worked for twenty-five years. He almost immediately became interested in diphtheria, which was rampant in the institution, and especially in the laryngeal cases. He was particularly discouraged with the results of tracheotomy; in fact, he says that in the first ten years of his service no tracheotomy case survived, and half the staff would not permit it to be performed on their patients, rather letting them die in peace so far as that was possible with such a dreadful disease. He soon conceived the idea, as had a number of others, of passing a tube through the throat into the windpipe to enable the child to breathe, and he worked industriously for twelve years at the problem of making a suitable tube. Needless to say, he had many discouragements, and it was eight years before he succeeded in saving a case. There was bitter opposition in his own hospital, where he was accused of experimenting on the babies. Many of the mothers removed their infants for them to die at home rather than let Dr. O'Dwyer put tubes in their throats and hasten their end. The New York Foundling Hospital still exhibits his early tubes and many casts of larynges, etc., made in his painstaking endeavours. His first idea was a bivalve speculum to open when in position, then a small straight tube, then he gradually introduced the swellings which enabled the tube to be retained. In 1888 he presented the profession with the intubation apparatus practically as used to the present day. As usual with any innovation, it was slow of acceptance. Most of those trying intubation being clumsy and inexpert failed, so that even in the last few years text-books issued by authorities in Great Britain say tracheotomy is more satisfactory. However, he lived to see intubation generally adopted in America and to see the introduction of the antitoxin treatment, which he eagerly took up, though many of his contemporaries were discouraged by the complications induced by it. His great discovery has resulted in the saving of thousands of children and is only recently being gradually replaced by other more modern methods.

The next stage, the discovery of a specific treatment of the disease, was inaugurated by two Frenchmen, Emile Roux and Alexandre Yersin, working at the Pasteur Institute. They laboured for a number of years at the subject and published the results of their work in three Memoirs between 1888 and 1890. They succeeded in isolating the toxin of diphtheria by filtering cultures of the organisms, and studied the effects of the toxin on animals, showing how the symptoms and after-effects of the disease were produced. This paved the way for the discovery of diphtheria antitoxin, which we owe to a German professor, Emil von Behring. He was born in 1854, and became a Prussian army surgeon, and later a pupil of the great Koch. After 1888 he worked in Koch's Institute in Berlin, and it was while working there with Kitasato on the toxins of diphtheria and tetanus that he demon-

strated that the blood of animals immunised by successive doses of attenuated toxins could be used as a preventive and therapeutic inoculation against the disease in other animals. This was published in 1890, but not until 1894 was the antitoxin prepared on a large scale for use in man.

The world-wide enthusiasm aroused by this discovery is familiar to all. It was thought that a specific had been found for the cure of all infectious diseases, all that was necessary was to discover the various organisms, immunise animals and use their blood serum. Unfortunately, all know how this expectation has failed and the peculiar combination of circumstances that make diphtheria antitoxin so efficacious. Its use was quickly adopted all over the world, but at first caused disappointment and bitter opposition. The original dose of 1,000 units, supposed to be sufficient for any case, we now know to be totally inadequate for a severe infection. Also, the unconcentrated blood serum at first used was bulky and difficult to administer. Sudden deaths from serum shock and the almost constant occurrence of the mysterious new serum sickness alarmed physicians. It was claimed that the new serum had a serious effect on the heart and that all complications were more common after its use (the latter was really true in a certain sense because more patients lived to have complications). Even to the present day it is common to blame all sorts of troubles on the use of serum, and many of the modern cults bitterly opposite it. However, the newer methods of concentration and refinement have removed most of the objections, and earlier and larger doses have steadily increased its efficacy, so that now the experienced physician no longer fears the disease, if only he sees the case in time before irreparable injury has been done.

So we come to the final period of prevention. Isolation and quarantine proved a failure in controlling the disease, but modern methods of immunisation promise to be more effective. It was soon found that while the use of antitoxin reduced the mortality of diphtheria to one-third or a quarter of its previous extent, the morbidity remained the same, *i.e.*, there were as many cases of diphtheria as ever, though fewer of them died. This turned attention to the various means of producing immunity. The induction of passive immunity by the use of small doses of antitoxin was introduced soon after the great discovery of the serum. Although this procedure undoubtedly saves many contacts, the immunity so induced is too brief to be of any great assistance in stamping out the disease. The introduction of the skin test for immunity by Bela Schick of Vienna made possible immunisation on a large scale. The possibility of inducing a lasting active immunity by the use of a toxin-antitoxin mixture, first suggested by Theobald Smith in 1907, was applied clinically by von Behring in 1913, and widely adopted in America. Later the use of toxoid or anatoxin, *i.e.*, toxin treated with formol, came into use.

To sum up the whole question, our knowledge of diphtheria has been of gradual growth, marked by many masterpieces of work by many men in many countries, the outstanding publications being those of Bretonneau, of Loffler, Roux, Joseph O'Dwyer, and of Emil von Behring. As a result of the work of all these men and of a host of others this terrible epidemic disease has been largely controlled. The estimate that 7,000 lives a year are saved in New York City from the improved death rate gives an idea of what has been accomplished.

Diphtheria has no longer any license for existing in any civilised community and undoubtedly will soon cease to be an important cause of death. Scarlet fever and other diseases promise to follow in its wake, and there is a good prospect that many of us will live to see isolation hospitals for contagious diseases closed for good and that branch of medical service a thing of the past.

The Development, Management and Care of the Normal Child

By S. J. USHER, M.D., Assistant in Paediatrics, Montreal General Hospital, Montreal

At first sight this subject seems to have very little to do with the nursing of sick infants and children. To know how to handle the abnormal or sick child, one has to know something about the development, management and care of the normal healthy child. Before I discuss the mental growth and development of the child it might be wise to say a few words about the nervous system. There are, first, the sense organs which receive tactile, painful, gustatory, visual, auditory, olfactory and articular impressions; second, the sensory nerves which carry these impressions to the spinal cord, where nerve cells receive and transmit the impulses or messages along motor nerves to muscles or glands. In addition, there is also the brain which supervises the work of the subordinates and which can originate movements that lead to action. It interprets the various sensory stimuli into sensations of touch, pain, taste, sight, hearing, smell, position in space, etc. It was first suggested over a hundred years ago that certain parts of the brain are especially concerned with certain functions. Reflex acts, like those of blinking of the eyelids, sneezing, opening of the mouth in babies at the sight of food, occur as the result of sensory stimuli received through sensory nerves by the cell stations in the spinal cord which reflect these stimuli along motor nerves, without the intervention of the brain. The brain is relatively very large at birth. This accounts for the comparatively large size of the infant's head. The brain grows most rapidly during the first eight or nine months. In idiots and imbeciles the brain is smooth and small and the skull is consequently small. However, the large size of the head does not necessarily mean great cerebral development; it may be due to rickets or may even be associated with imbecility due to hydrocephalus, that is, water on the brain. At birth the baby's first movements are automatic and reflex in character, that is, its spinal cord is functioning and not its brain. It can cry and suck and it also has a very powerful grasp. This grasp gradually weakens as the baby gets older. Within a few weeks the baby shows some sign of pleasure when a brightly coloured object or light is shown to it. It also shows evidence of memory so that when held in the position usually assumed in feeding it makes movements with its mouth expressive of the desire to be fed. By the end of the third month it can generally recognise its mother. It will wink if a finger is brought close to its eyes. At four months it can hold its head erect. It can do some purposeful act, such as looking for an object that is shown to it. At six or seven months the baby can sit up erect when supported. It can reach an object, can laugh and can play with a rattle. Teething begins at about this time. At nine months it can sit up unsupported. At ten to twelve months it can stand up with support. At twelve to fifteen months it begins to walk and to utter some words. This is a very bald summary of the baby's rapid development during the first year. Arnold Gesell's book on Infancy and Human Growth will give you a better idea of the relative differences at the various monthly levels.

While considerable variation may occur in perfectly healthy children, great delay in the development of these acts is due to some physical or

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mental cause such as rickets, general malnutrition, paralysis or mental deficiency. Hence, by noticing the age at which an infant acquires the ability to perform certain acts, it is possible to estimate to some extent the degree of his muscular and mental development. If speech is not developed by the time the child is three years old, mental deficiency may be suspected — provided that hearing is not at fault, or the child is not suffering from debility due to some prolonged illness. The old saying, "Mens sana in corpore sano," a sane mind in a healthy body, is generally true. It has been found that mentally backward children suffer half as much again from malnutrition and naso-pharyngeal obstruction and three times as much from defective hearing as normal children.

The development of the various senses takes place rapidly. The senses of taste and smell and touch are probably well developed at birth. For the first few days hearing is almost entirely absent. It rapidly improves and soon becomes very acute. Vision is very feeble at birth because the visual centre in the brain is not yet fully developed, and before six weeks the baby is said not to be able to focus its eyes. It begins to recognise objects after the third month.

There are characteristic sex differences. In addition to the obvious anatomical and physiological differences which are primarily associated with the function of reproduction, the sexes differ in the following respects: (1) Metabolic—The metabolic rate is on the average somewhat lower in the female than in the male. A high metabolic rate implies a great expenditure of energy; a low rate means a great storage of energy. Hence man uses up more, and woman stores more energy out of the food they take. (2) Endocrine—The internal secretion of the ovary produces the secondary female characters, that of the testes the secondary male characters, including the break in the voice. Up to the age of ten years the annual gain in weight is nearly the same for both sexes, boys being on the average a pound or a pound and a half heavier than girls. During the eleventh, twelfth and thirteenth years, girls gain more rapidly than boys and pass them in weight. The thirteenth is usually the year of greatest increase. Boys begin to gain rapidly in weight during the fourteenth year and soon pass the girls. With them the sixteenth is usually the year of greatest increase. With both sexes there is seen as a rule a slowing up of growth before the rapid increase of puberty begins.

To be able to manage children properly it is important to know something about the child's emotions and the dynamic urges that underlie a child's conduct. The most important emotions in early childhood are those of fear, anger and love, as each of these plays its part in the formation of character. Children are instinctively afraid of the dark, of strangers and loud noises. Such fears gradually disappear as the child grows older and is in a position to realise that the danger is only imaginary, but he can be helped to overcome it by explanation and by a demonstration of the absence of fear on the part of his parent or nurse. The child's vivid imagination is also a source of fear. Hence great care must be taken in the selection of the kind of story told to a child. The policeman or the doctor should not be used as a sort of bogeyman to frighten a child. Anger is the result of some annoyance such as physical discomfort, fear or deprivation. This emotion is accompanied by the instincts to scream and strike. Such outbursts of temper should not be encountered by loss of temper on the part of the nurse, but should be treated with tact and sympathy. He should be left alone for the time being, and when the fit of temper has passed off, should be made to realise that not only was there no real cause for such an exhi-

bition but that he gains nothing by that kind of conduct. Each emotion requires an outlet. Fright, for instance, will find its outlet in a fit of crying, which forms a safety-valve for the pent-up nervous tension. This should, therefore, not be immediately checked or repressed, otherwise the delicate nervous system might suffer considerable damage. The proper way of dealing with it is to soothe the child and try to divert its thoughts into other channels and later induce it to tell about the incident. Thus the child will feel that he can always turn to you when in trouble. In addition to these emotions I have described there are, as I have mentioned, dynamic urges underlying a child's conduct. These are of especial interest to anyone looking after children. There is love of affection—every child seeks affection. There is also love of attention—every baby and child demands it and wishes to be the centre of interest. Finally there is the love of power. Every child has a desire to be master. Every normal child wants these things. He works for them and as far as he can be said to plan, he plans his life so as to get them. If he doesn't get them in reality, he builds up a life of fantasy and so satisfies his desires. A normal amount of each of these is due to every child, but they are perfectly willing to take much more than their due if given the chance.

Another great determiner to a child's character and a great aid in the management of children is suggestibility. The child from birth on is highly suggestible. This applies especially to the pre-adolescent or early adolescent years. A child will accept our estimate of him. If we assure him he is nervous he can develop all the symptoms. All our suggestions should be positive ones, that is, we must say what we want him to believe. For example, we may tell him that he is perfectly healthy and that we are surprised to see him behaving this way. The child must be taught that he will only get our affection and attention as a reward for his good conduct. Children are very imaginative and imitative. Their vivid imagination unconsciously makes them tell untruths. Their imitativeness makes it very necessary not only to isolate them from other children suffering from certain functional diseases such as stammering, habit spasm, chorea, etc., but also that they should be placed in surroundings with right influences. Further, it is his imitativeness and lack of critical faculty that renders the child so amenable to suggestion. As the child grows and begins to sit up or walk his activity grows, and fussy and impatient mothers or nurses are apt to order the very active child to sit still or not to do this, that, or the other thing. Such interference with the child's normal activity, especially when he is engaged upon some new task which he is trying to learn and when his whole nervous system is in a state of high tension, is apt to have the same effect upon it as trying to keep the steam in a kettle by stopping the spout. A nervous explosion may result and the child's nervous mechanism may suffer considerable damage. The nurse or parent should be sparing in the use of "Dont's."

The ideal training centre for the pre-school child is the nursery school. Although already a part of the English public school system it is only as yet largely experimental on this side of the water. The nursery school takes children from eighteen months or two years upward to kindergarten age, and gives them complete training in social and health habits. In its proper form it gets the babies early in the morning, provides all their meals, teaching them by group participation how and what to eat, supervises their play—much of it outdoors—and their relationships to one another, settles them in their cribs for the after-dinner nap, and restores

them to their homes at bedtime. The school takes a group of little folk and teaches them by actual experience how to be social animals and how to care for themselves. Another method of teaching children up to two or three years is by the Montessori system. This is divided into three parts. The first part is motor education, which consists in giving order and direction to the child's uncoordinated movements, leading him to do those actions which he is aiming to do. These muscular movements have reference to walking, handling objects, personal care such as dressing and undressing, domestic work, gardening, rhythmic movements, etc. Thus for the purpose of dressing and undressing, there is a collection of frames to which are attached pieces of stuff which can be buttoned, hooked or tied together. The teacher performs on these frames the various necessary movements involved in fastening or unfastening our clothing, one act at a time and very slowly in front of the child. The child is then given the frame and is encouraged to repeat these actions for himself. In this way they soon learn to dress and undress themselves. Similar methods are adopted for teaching other movements. The second part is sensory education. The child is given rows of cylinders differing either in height only, or in diameter only, or both in height and diameter. The exercise consists in placing them in the appropriate hollows in a block of wood. By repeated trial and error he soon learns to fit all the cylinders into their appropriate holes. In this way he learns to appreciate differences in dimension. Other exercises have been devised to train the sense of touch, temperature, as well as the appreciation of colour. The third part is language and writing education. The main principle of the Montessori system is that of autoeducation, in other words, education without guidance or interference by the teacher. The teacher mainly shows how a certain thing is to be done and leaves it for the child's innate instincts of curiosity and imitation to repeat the exercise and learn from his own mistakes. The system is a very attractive one but is only applicable to children who are mentally perfectly normal.

The formation of correct habits from birth onward, is of great importance in the proper management of children. The constant repetition of any act results in the formation of a habit. This is particularly the case in children and the younger the child the more easily is the habit acquired. The nervous system of the child is still plastic, so that a very few repetitions of the act will be sufficient to leave a lasting impression. It must be remembered that it is as easy to train a child into good habits as into bad ones, and that it is as difficult to get out of a bad habit as of a good one. Hence, the training of a child into good habits should begin at the earliest possible moment, immediately after birth. The first habits to be taught at this early age are regularity of feeding and of evacuation of the bowels. It is of the greatest importance that a mother should be taught not to lift the baby every time it cries and nurse it or put a bottle in its mouth. As the child grows older, the food habits must be enlarged in scope so that the child is accustomed to eat any food that is offered to it without coaxing. It must also be made to acquire habits of kindness, unselfishness, restraint and self-control, self-reliance, accurate observation, personal cleanliness, punctuality, truthfulness and courtesy. Good and bad habits can also be acquired by associating any particular behaviour with some particular conditioning stimulus. Thus, by holding out a baby over a receptacle at times when a movement of the bowels is found to be taking place naturally, a conditioned reflex is in time established between the sight of the receptacle and the reflex

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act of defæcation, thus ensuring clean habits even in very young babies. Similarly, allowing the baby always to sleep in a dark room will render it unable to fall asleep in a lighted room, but by varying the illumination of the nursery from time to time, the baby can be trained to go to sleep under different conditions of lighting. If the same flavouring agent is always given to a child to conceal the taste of a nasty drug an association will be established between the drug and that flavouring agent so that a dislike or even a feeling of disgust will be established in the child for that particular flavour. Such examples can be multiplied almost indefinitely and their value in child training will be easily appreciated. The child should be trained along an ascending scale of acts of endurance and self-denial, and deeds of kindness which involve subordination of self to the interest and benefit of others. He must be trained to withstand temptation, even if left alone with some chocolate, jam or other dainty of which he is particularly fond, and he must learn to give up a favourite toy to another child who is in greater need of it than he. In this way self-control will gradually be acquired as a habit. The teaching of such good habits will thus lay an excellent foundation for the moral development of the child, which after all is as important as his proper physical development.

It also is necessary for you to have a proper understanding of the child's play requirements. The child needs first and foremost his own room and his own play-yard. They give him physical security from the mishaps that may overtake him in the adult room and they liberate him from the presence of forbidden things. He becomes an independent social unit until such time as he is old enough to be interested in the garden and house of the family. During early childhood, the little boy or girl, whether rich or poor, loves to play with sand. The children of the well-to-do will build sand castles at the seaside or in their gardens, those of the poorer classes will make mud pies whenever they get the opportunity. Other games at about the same age or a little later are those of adventure in which secrecy forms a part. They will play at hiding, pirates, big game hunting, etc. Later on, games of ceremonial and of construction occupy the child's mind. The boy will play with mechanical toys, build houses, boats and other structures, whilst the little girl will play with her dolls. At a later stage still, the child shows an interest in organised games such as marbles, cricket, football, etc. It is necessary to recognise these various stages if we want to be able to supervise a child's play intelligently. Another thing we must recognise is the child's natural curiosity. This trait is merely a natural appetite after knowledge which should within reasonable limits be encouraged. The child who takes his engine to pieces to see how it works is simply carrying out a natural and perfectly praiseworthy impulse. All toys given to children should be such as to enable them to satisfy their legitimate curiosity without any injury to themselves or undue expense to their parents.

A Day with the Clinic's Visiting Nurse

By BLANCHE EMERSON, Edmonton, Alberta

The nurse stirred wearily on her pillow, for the day was returning, bringing with it the usual petty round of cares and commonplace tasks.

Petty indeed, they seemed at this particular hour of the morning to the nurse who knew she must rise and go visiting. Well she knew that the same questions asked hundreds of times before would be asked and answered hundreds of times again. True, as someone has pointed out, the same person hadn't been told the same thing a hundred times but in the rush and hurry of the day, it is apt to seem that way to the busy nurse.

Before finally tearing herself away from her comfortable bed she let her vagrant fancies carry her where they would, and this morning they played a little game called in her childhood, "Let's pretend." Let's pretend that I don't have to be patient, kind and tactful to the families I have to visit today, and can just say to them what I think.

"No, Mrs. Jones, it is not a good plan to keep the baby awake until ten o'clock at night so that she will sleep later in the morning. Mornings were made to get up in, not to sleep through."

"And Mrs. Brown, how many times have I to tell you that castor oil is never given to cure constipation."

"You — Mrs. Smith — know well enough that you are only trying to get out of giving baby its daily bath, for such babies need baths even more than well ones."

"No, Mrs. Hauptheiser — sauerkraut, liver, sausage and coffee have never yet been found on the diet list of any young child."

"You wonder, Mrs. Ching Lee, why your baby is so restless—Well, let me tell you, she wasn't sent for you to use her as a toy to amuse your Chinese friends with. She has a crib, why not let her stay in it."

Resolved to smile—if possible—at Mrs. Slevensby and say, "So you don't approve of our clinic methods? Oh, well you came of your own accord, we didn't send for you."

Laughing to herself as the thought of the replies she might receive in return for information imparted in this way, she was now thoroughly awake and ready for anything the day might bring.

So she went visiting. . . .

Her first call was on a Ukrainian family: A man opened the door who could not speak English. He called, and in they came: men, women and children to find out what was going on. One of them, a man, acted as interpreter — questions were asked and answered on both sides, and considerable advice given, it even being suggested to them that they should learn to speak English. After examining the baby and other children of pre-school age, there was much smiling and nodding of heads, and the nurse passed on to the next family.

At this home, conditions were not all that could be desired. The father had been out of work for some time, and too proud to ask for help. The family had struggled on until they were almost at the end of their resources. A heater with one lid was their only means of cooking a meal. As tactfully as possible the nurse mentioned that she had some clothing that would fit Mary and Johnny, and enquired if she might bring it around. The mother would not accept for herself, but did for her children. A kindly group of women provided a cook stove and work was secured for the father, so the burden was lightened a little.

In the next home she was met by a cheerful little Cockney woman who announced: "E's 'ome, that's wot 'ee his, nurse, and don't be 'ard on

'im, for hit wasn't 'is fault, it was false hevidence and henemies that put 'im where 'ee was." Her prodigal had returned.

Then came a visit to a young mother who was caring for her first baby. Much time was spent here. The little mother said she was far away from her own mother, and a stranger in the city, and so the clinic with its doctor and nurses filled a large place in her life during these anxious days.

There was the negro widow, who had brought three nameless waifs into the world during her widowhood, the last two being twins, who when asked how she was getting along began to weep, and as the big tears dropped down over her dusky face, exclaimed: "Ah is endeavouring to lead an upright life. Ah reads ma Bible to mah chillen every day for I does want them to be good." The kinky-haired twins looked up from the box where they were playing, and the other little pickaninnies gazed at their mother evidently wondering what it was all about, and then went quietly on with their play.

Then there was the little foreign widow, whose husband had been dead only a short time, who happily announced that she was being married again Saturday morning at the Holy Maternity Church on the South Side.

The little French-Canadian baby, fourteen months old, who couldn't walk, but who could speak both English and French, who looked up at the nurse and smiled, and in the most approved fashion said, "Oh yeah."

The woman who felt so sorry for the next door neighbour because she had just had an "amateur" baby, and it was so wee and needed so much attention. Would the nurse mind going in to see her.

The mother who had lately lost her child and couldn't understand "why?"

The expectant mother, so full of fears and age-old superstitions, who had not yet seen a doctor, for whom arrangements must be made.

The jolly Hungarian, so many of whom lived in the same block, who greeted the nurse joyously and noisily, who spoke to her of the vine-clad hills of Hungary, of the beauties of Budapest, and of their present joys and sorrows.

The little pre-school girl who came running eagerly to meet her to tell her she was drinking milk at every meal now, and eating spinach and carrots, just as the doctor said.

The chubby-faced boy, who shyly said, "I know you; you're Clinic."

So the day wore on. Many were the stories told: sad stories, gay stories, stories full of tragedy, or pathos. Yes—and many were the questions answered, but somehow the nurse didn't find them irritating now. She had entered into their joys and sorrows, and had gained their viewpoint.

MY CREED

I believe in Canada.
I love her as my home.
I honour her institutions.
I rejoice in the abundance of her resources.
I glory in the record of her achievements.
I have unbounded confidence in the ability of her people to excel in whatsoever they undertake.
I cherish exalted ideals of her destiny as a leader among world nations.
To her I pledge my loyalty.
To the promotion of her best interests I pledge my support.
To her products I pledge my patronage.
And to the cause of her producers I pledge my devotion.

By the Hon. Henry H. Stevens,
Minister of Trade and Commerce.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss MILDRED REID, 10 Elenora Apts., Winnipeg, Man.

The Case Study Method of Ward Teaching

By EUGENIE M. STUART, Toronto General Hospital, Toronto, Ont.

The principles underlying the present Case Study Method of teaching are not modern. From nursing history we find that Florence Nightingale, in the Nightingale School in St. Thomas's Hospital, London, England, encouraged the students in a method of study similar to our present day Case Study Method. The first we hear of the case study is not in nursing, however, but in law. In 1871 Dean Langdell of the Harvard Law School introduced the case study with a definite purpose—that of seeing the entire study of law built on the study of separate cases. From that time till the present the Case Study Method has been used in various types of education. However, only recently has it become utilised to any great extent as a means of ward teaching in schools of nursing.

The main objects of the case study are:

(a) To have the student gain an understanding of the patient as a whole, to see the patient as still a member of his family and the community.
(b) To help the student seek information about her patient in an organised form.
(c) To develop powers of observation in the student.
(d) To emphasize the importance of understanding the treatment applied for the patient's recovery.

The time in the nurse's training and the number of case studies written are much debated points. It is felt that any time during the student's training is suitable as long as she is actually nursing the patient. The question arises—should preliminary students write case studies? For the past two years our students have been writing one study while engaged in the nursing of two patients at the termination of their preliminary term. At this early period in their training this method of ward instruction teaches them to help themselves and also how to study from text books. The number of case studies to be made is an important point and one in which the time factor of both student and supervisor plays a great part. In general it may be said that it is much better to have the students make one complete case study in any service, one which really allows for thought, study and observation, than to have a number of superficial reports made which tend to become routine. At least one study in each of the medical, surgical, dietary, out patients' and obstetrical departments is advised and more if time permits.

My knowledge of the method by which the Case Study Method is used in various schools is rather limited and therefore the method of procedure in Toronto General Hospital only will be outlined.

The student's experience in each of the surgical and medical divisions is three months. When the student is assigned to the department the usual informal conference is held on the ward with the head nurse: duties outlined along with ward routine and explanation of special equipment. Some time during the first week a formal, individual conference is held with the supervisor of the department in her office. The time taken for this conference varies with circumstances, such as the seniority of

(A paper read at a meeting of District No. 5, Registered Nurses Association of Ontario, June, 1931.)

the student, her previous experience, her adaptability, but approximately one hour is spent. During this conference a general outline of the types of patients on each of the medical or surgical wards is sketched. To the student is emphasized the double responsibility: (a) to the hospital for the care of the patient; (b) to herself for her own education. The advantages of knowing thoroughly each patient are pointed out, this by a synopsis of the patient including his date of admission, condition on admission and progress, occupation, social background, and problems, provisional diagnosis, treatment, nursing care, health instruction for each patient and preventive measures applicable to the individual patient. Special emphasis is laid upon the fact that the patient is still a member of his own family with social needs and relationships. The checking up of all material with reference books, magazines and by discussion is stressed. At the end of this conference a record is made of the student's attitude and insight into problems. A small note book is provided in which the nurse may make her summaries.

When the student begins her second month in this division a second conference is held between the student and supervisor. A complete explanation is made of the case study and note is made of the progress of the student during the first month. The greater number of schools using the case study have a printed form which serves as a guide for the student. The headings in this form are suggestive and act as a guide only as to what information would be helpful in understanding the needs of the patient. They are meant to stimulate and direct keen observation and to teach the students to interpret their observations. The student is advised to select the patient whom she wishes to study and submit her choice to the head nurse who will discuss with her the wisdom of her choice, and determine whether or not the student needs help and guidance before continuing with it.

The sources of information should be merely outlined. The student should be encouraged to find these for herself. The main source of information is the patient. The student must be impressed with the importance of the development of tact in talking to her patients. The doctor's clinical chart is a valuable source of information, but as the case study is strictly a nursing study the chart must be used with care and understanding. The head nurse is the individual who can give the student more help in gaining material than any other person. She has seen the patient daily since admission, noted his progress and the results of treatment. The social worker may frequently be called upon and possess the knowledge which emphasizes the relationship between the home conditions and responsibilities, and the patient in the hospital. Home visits with the social service worker are advisable but not always possible. X-ray films often show the abnormal condition existing, possibly correcting some misconstrued idea the student has already gained. The dietitian in many cases can give valuable help.

The student is given two weeks in which to write her case study. At the end of this time it is handed in to the head nurse who reviews it with the student and then it is given to the supervisor. The supervisor then arranges for a third formal conference with the student in the supervisor's office. An ideal situation would be to have the head nurse attend this conference also. At this time the study is reviewed by the supervisor and any corrections made or false impressions rectified. Any criticism is as far as possible constructive rather than destructive and the study is graded. A permanent record is kept of each student's interviews and results with grade of study.

Case Studies form excellent material for teaching and discussion in formal classes of nursing, dietotherapy and materia medica. By this means material is collected, not only in specific cases and about nursing in general but knowledge is organised in a form which permits the checking of work to note progress made in content and method, to compare facts presented by the study of a great many cases of the same class and of different classes and to select facts common to all cases of the same class.

Our statistics show that the average time spent on one case study varies from nine to twelve hours.

The Case Study Method of Ward Teaching is still so very young that it is difficult to predict the outcome. The majority of schools which have already adopted the method feel it is a great advance and there seems to be a growing interest and appreciation of the use and value of case studies.

In resumé, I might say the values of this method of teaching are:

(1) A better nursing through a better understanding of the patient.

(2) A better knowledge of how to study by the student.

(3) A wider knowledge of available material.

(4) A better knowledge of the method of applying material gained in nursing one patient to the nursing of other patients.

(5) It correlates theory with practice.

Educational Problems

By Dr. G. CLOWES VanWART, Fredericton, N.B.

Permit me in the first place to express my appreciation for the honour that has been conferred on me by the New Brunswick Association of Registered Nurses. There is no manifestation of kindness and approval which could have pleased me more.

The subject as on our programme is "Educational Problems." We have our graduate nurses who have completed successfully three years' training from a standardised hospital, many of whom have passed the requirements necessary to become a registered nurse in New Brunswick.

The age of admission and the applicant's preliminary education vary in New Brunswick according to the hospital. After becoming a graduate nurse many of our nurses then take a post-graduate course at a different hospital or college to specialise in one particular phase of nursing.

We still have with us the practical nurse and the midwife who fill a distinct public need. The majority of these have not had the advantage of much special training. The outline which I am about to suggest is for a uniform and more highly developed training. This is an educational problem in itself.

The aim of a school of nursing is to develop a type of professional education for the student nurse and thus to contribute better service to the field of nursing.

At present the supply of nurses is greater than the demand and the greatest handicap of many a nurse is her lack of preliminary education.

I would suggest that the entrance requirements of the student nurse to the school of nursing should be the same as that of a full-course student entering the first year of a university for a degree. Also, that the applicant must be unmarried and at least eighteen years of age and be able to show evidence of good character as well as physical and mental fitness.

The course of training must follow a definite educational plan. One must always remember that the patient is the first consideration and that the education and training of the nurse is to lead to efficiency in his care.

(A paper read at the annual meeting of the New Brunswick Association of Registered Nurses, September, 1931.)

Faculty of Public Health University of Western Ontario LONDON

There would be two distinct courses: The first, or Course I, which would cover a professional curriculum of eight months at a university and three years at a standardised school of nursing. This course would lead to a Diploma in Nursing.

The second, or Course II, which would cover approximately a professional curriculum of two years and four months at a university and three years at a standardised hospital. This course would lead to a Bachelor of Science Degree in Nursing from the university and a Diploma in Nursing from the school of nursing.

The tuition fee at the university should be moderate and rewards for efficiency in studies be provided by scholarships.

The synopsis of Course I would be as follows: All instruction in the first year would be given at the university. The student would receive a preparation in the basic sciences upon which to build her clinical experience so that she would be more intelligent in giving nursing care to her patients.

The subjects taught while fitting into the regular freshman year at the university would be selected for their value as a professional preparation. Following a vacation of four weeks the student would enter the school of nursing for a course of eight weeks, in which she would study elementary nursing practice on the wards. This would be done before the first fall term in the school of nursing.

During her first year in the school of nursing, instruction would be continued in nursing in medical and surgical diseases by means of classes and conferences. An average of 18 hours a week should be spent acquiring skill through practice in the care of patients.

The second and third years in the school of nursing would be devoted to the specialities in nursing and to the practice in the various specialised departments in the hospital and public health field.

The synopsis of Course II would be as follows: The first two years or pre-nursing years would be spent at the university, where instruction would be given in the general cultural subjects. This would give the student the opportunity to share in the social life of the college as well.

On the completion of the two pre-nursing years at the university and after a vacation of four weeks on the completion of this second year, the student would enter the school of nursing for a summer course of eight weeks and begin nursing practice on the wards. Then she would enter the first fall term at the school of nursing. The course of study would deal with the causes, prevention and nursing care of all varieties of disease.

The last four months of the fifth year would be spent in the university completing the required work for the university degree and making a study in the particular field in which the student is most gifted.

Dietetic experience would be gained in the hospital dietary department, while operating room procedure and surgical technique would be learned in the general operating rooms. Through the department of obstetrics and obstetric clinic the student would be given a thorough course in ante-partum and post-partum nursing. The lecturers to the student nurses should be full-time teachers.

After completing this training the nurse would be ready for the nursing care of the sick, the teaching of public health in the hospital and homes of the community or teaching administration positions in schools of nursing.

While in Peiping, China, I had the pleasant experience of visiting a well-organised hospital. A course quite similar to this is followed by the school of nursing connected with the Peiping Union Medical College there.

If this system is workable in the Far East, why not in New Brunswick? The principles of nursing are the same throughout the civilised world. It is the spoken language and customs

which are so different in the East and West. We both have our well-organised hospitals and universities.

Improvement in our present system is desirable and any constructive suggestion should receive earnest attention. A satisfactory solution might be affected by a conference of representatives from the New Brunswick Association of Registered Nurses, the Faculty of the University and those responsible for the curriculum of the schools of nursing. In this way much could be accomplished in the exchange of ideas and the best methods of their application.

In this brief paper I have omitted purposely the details and have given only a suggestive outline for a more thorough and efficient course of training for nurses.

An affiliation between training schools of nursing and a Canadian National Registration Nurses Examination Board would enable the graduate nurse to become registered throughout Canada.

In conclusion, I may say, that we must advance with the signs of the time, as in the past our graduate nurses from New Brunswick have brought much honour to their training schools from both the East and West.

Criticism of Standard Curriculum as Outlined in The Canadian Nurse

(By Request)

My first thought is the great difficulty in planning any standard course of study for Canadian Schools of Nursing where there is such wide variance in the number of beds in accredited schools (50-1000), and in the educational requirements in different provinces for students entering these schools.

Would it not be wise to have a uniform educational requirement for admission obtained prior to planning a curriculum, or plan for it at the same time as for the course of studies?

With such great differences of required educational standing as exist now in many of the provinces, it is almost impossible, as I see it, to carry on any standard course in schools of nursing. Grade XII (junior matriculation or high school graduation) as required admission standard would certainly simplify present conditions and remove many existing difficulties.

The weak point in any standard curriculum is that unless a well-equipped instructor is available there is danger of camouflage. Who has not known the difference between the printed prospectus and the actual teaching in some schools of nursing?

In the curriculum presented I consider that too much time is planned for class work in the junior year. An allowance of three hours a day is practically impossible in a busy hospital. This three hours a day class work works out to be really six hours a day away from wards (two hours recreation, three hours class and one hour for meals). I would suggest a longer preliminary period, one of five months. Admitting students in September and February, each class would get through with a larger number of class-periods and be ready for the wards. These students are of the least value to the hospital in these first months, and are fresh for study.

If we investigate the high school curriculum we will find chemistry, personal hygiene, health and physical education, home economics (foods) and other subjects closely allied to those we

require in schools of nursing, and which can be better taught in high school, where laboratory and other equipment is available, rather than in the hospital where, except in the largest ones, these exist only in the sketchiest form, if at all.

All these subjects may not be included in the programme of the high school studies in all the provinces; effort on the part of those interested in nursing education will prove that little difficulty is encountered in obtaining a sympathetic hearing, but rather that assistance is given. With vocational directors in so many schools the path is much easier. We do not need to ask for a special course to be provided, but with the co-operation of the Provincial Board of Education and two or three principals, much can be done by proper selection from the curriculum already existing in the high school systems.

Some provision for mental hygiene and more psychology should certainly be included. Probably affiliation with mental hospitals will solve that problem. Psychology carefully taught seems to me to be one of the most important subjects for the improvement of the nurse's technique and knowledge of the patient, who is never quite normal.

I query the value of massage being included in standard curriculum. In the smaller schools, at least, it is practically impossible to obtain a first-rate fully qualified masseuse to give such a course, and there is always the danger that the physician will feel justified in ordering a "massage" and more harm than good would be the result.

Our great aim, or so it appears to me, is to bring continuous pressure on Provincial Departments of Education to provide a special high school course leading to matriculation; and till then to utilize the subjects already at hand; and in addition to getting better teaching in subjects required by nurses, we also save time in the school of nursing, which would allow re-arrangement of the curriculum to the advantage of student and hospital.—H.R.

The Grading Committee Plans

The Committee on the Grading of Nursing Schools (United States) held its semi-annual meeting on November 20 and 21, 1931. The meeting was perhaps the most interesting and constructive of any which have occurred so far in a long series of successful meetings. Briefly summarised, the chief decisions which the committee reached are as follows:

1. The committee plans to continue its work for two more years if funds can be secured for that purpose. It starts the new year with enough money to carry the work well into the spring, and there seem reasonable prospects of securing additional gifts from a number of different sources. The committee believes that to stop the work at this time would leave several important projects unfinished.

2. The committee has agreed to make a second grading. This will make it possible for schools to discover how much progress they have made since the first grading two years ago. This work will start early in January. All schools listed on the Accredited List, recently published by the National League of Nursing Education, will be invited to take part. Those which accept will be sent monthly installments of report blanks, in very simple form, so that no undue amount of work will be called for at any one time. The study will probably cover the greater part of 1932,

and reports will be sent back to the schools which take part as promptly as possible after the tabulations are completed.

The committee has agreed that no white list or black list based on this second grading shall be published at this time. It is, however, the present hope of the committee that, when the study is through, it may be possible to compile the results in a series of educational comparisons which may be made available to individuals who ask for specific information. In other words, there will be no published list showing how one school compares with another. Neither will there be any single mark or rating. Schools will, however, be compared on a fairly large series of different items; and it is the hope of the committee that the material will prove sufficiently valid so that information concerning where a given school stands on any particular comparison may be made available to inquirers. It is the belief of the committee that the time has come for some information based on gradings to be made available to prospective students and other interested persons.

Schools taking part in the study should, therefore, understand that while no general publicity will be given to the results for individual schools, nevertheless the material will probably not be considered confidential in the same sense as was the material of the first grading. It is understood that some few schools will hesitate to take part in a grading made on this basis, but it is believed that the better schools in the country will be glad to avail themselves of the opportunity.

3. The Committee on the Grading of Nursing Schools is already attempting to formulate what may be thought of as minimum standards, which every school of nursing must meet if it is to call itself a school. These standards will be placed so low that there can be little excuse for any school not to meet all of them. Due consideration will be given to the fact that many schools are financially handicapped and most work slowly towards improvement. It is felt, however, that the time has come when there should be some general agreement as to what may properly be considered a true school of nursing.

4. Towards the end of 1933 the committee plans to publish a final report, signed by the full membership of the committee. Work on this project is already under way. The report will include, first, discussion of the problems concerning nursing education as the Grading Committee has seen them, and, second, whatever recommendations the committee feels qualified to make, leading towards the solution of these problems.

5. The committee has now in preparation and hopes to place in published form by the end of 1933, a practical handbook of the methods of grading which have been evolved through committee experience. Such a handbook could be used as a tool for grading or accrediting by local or national organisations. It would be subject to revision from time to time, and could be adapted not only to the questionnaire method, but to the necessities of studies made through personal field inspection.

By carrying through these various projects, within the next two years, the committee believes that it will have met, in so far as is within its power, the chief needs of the nursing and allied professions.

The programme as adopted is a heavy one. The committee feels fortunate in having secured for a limited period the services of Miss Ethel Johns, R.N., who will make the necessary field contacts and will take an active part in preparing material for the final committee report. Miss Johns has just completed an important service of a somewhat similar kind in connection with the School of Nursing, which, under the direction of Miss Anna D. Wolf, is now being organised in connection with the New York Hospital-Cornell Medical College project.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

The Conception of Cancer One Hundred Years Ago

By N. E. BERRY, M.D., Professor of Urology, Queen's University, Kingston, Ont.

Cancer presents the most formidable challenge which confronts the medical profession today. Possibly no subject attracts more research and certainly he who brings forth the solution will be the greatest benefactor of the age.

It is of interest to examine the writings from the School of Medicine in Paris at the beginning of the 19th century. They were really in advance of us today because they knew the actual cause of cancer. It was, they said, due to an engorgement and drying up of lymph in the affected part. This became transformed into the virus. How it came about was a bit puzzling but was explained easily by saying that it depended on vital forces. They scoffed at the ancients who thought it was the result of certain deleterious qualities of the bile, a yeast or a coagulating acid. They knew the actual cause and were only waiting for a specific similar to mercury for syphilis. Of course syphilis and gonorrhoea were at this time considered as different manifestations of the same disease and here again they were certain mercury was a complete cure. As a matter of fact cinnabar (mercury sulphide) had been used for centuries by many Asiatic tribes who burned the ore and sniffed the fumes to cure themselves of syphilis. Unfortunately here again we are not so efficient, we cannot cure syphilis now by mercury alone.

They divided the contributing causes into external and internal. In the first group they recognised the deleterious effects of various forms of prolonged irritation and their observations were accurate. Many writers call attention to the habit of repeated application of caustic to warts on the face as being a prolific cause of cancer. As to the second group or internal causes, their explanations were more fantastic. Chief among these causes is inflammation when it ends in induration and the cessation of an habitual discharge; such as from haemorrhoids, or in women, from menstruation. This latter was recognised as the cause of cancer of the breast and of the uterus. But it could also cause cancer elsewhere as a case is recorded of a woman who was attacked with a cancer of the face following a derangement in the menstrual function. It had been thought that this resulted from the blood being carried to the affected part, but that theory was being cast aside, especially since it was admitted cancer could begin in women whose functions were normal. Engorgement of the breast was a common cause of cancer and similarly engorgement of the male glands due to syphilis. It is easy to understand this latter hypothesis

since the two conditions could not possibly have been distinguished with the methods then at their disposal.

Many other factors contributed in certain cases, e.g., a life of sadness, sedentary occupation, long and deep meditation, etc. It was thought that these factors were active through slowing of the circulation. Similarly there were certain subjects of a disposition which favoured the development of cancer, e.g., those of a bilious temperament, melancholy, etc. Even shame might cause cancer to grow rapidly in certain individuals who had previously had a slowly growing tumor.

They were not quite so certain as to the influence of heredity. It was doubtful if a person suffering from established cancer could procreate and, therefore, there seemed little likelihood of this. But there was no doubt as to its being infectious. An instance was cited where a surgeon was attacked with cancer of the mandible after having tasted the virus (which he found quite sour.) Similarly children had been infected from nursing a breast which was the seat of cancer. Animal inoculation, too, had proven its transmissibility. Here again they were in advance of modern science for we are quite unable to do this now.

Most interesting of all are their speculations as to the actual nature of the virus of cancer. Some regarded it as an alkali, others as an acid, but they had to admit nothing more was known of it than of the other viruses.

Today we know the nature of these other viruses, what they saw through a glass darkly we see face to face: we smile at their hypotheses, most of which we now know are wrong but we really know nothing more as to the actual cause of cancer than was known one hundred years ago. Let us hope that before another fifty years our ideas will be equally ludicrous and that the real cause of cancer will be as familiar to us as the typhoid bacillus is today.

ANNUAL MEETINGS

Manitoba Association of Registered Nurses—Legislative Buildings, Winnipeg, at 3 p.m., January 14, 1932.

Association of Registered Nurses of the Province of Quebec — Central Y.W.C.A. Auditorium, Montreal, January 25 and 26, 1932.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section.
MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

A Busy Day on the Tobique

By EDNA GAUNCE ROSS, Riley Brook, New Brunswick.

[That pioneer nursing is not confined to the "younger" section of this country is evidenced by the graphic account of a busy day, rather days and nights, of the public health nurse on the Tobique River, N.B. Mrs. Edna Gaunce Ross, whose headquarters are at Riley Brook, covers a district of about thirty-five miles in length up and down the river. She not only takes care of the bedside work, but does the school nursing in the several schools of the district, infant welfare and tuberculosis work, to say nothing of the thousand and one calls that are listed as "social service." The service here is a continual adventure, and in winter an extremely arduous one, there being no means of transportation except horse and sleigh. Financing of the service is covered by the Department of Health, the parish and the Tobique Salmon Fishing Club, a club of New York sportsmen, many of whom have been glad to call upon the nurse in an emergency, and who through years of association with the farming people of the district have taken a keen interest in the welfare of the community.—H. G. D.]

About the middle of April, having sat up with a boy all night, we decided to take him to the doctor, a distance of twenty-seven miles. At 9 a.m. we were ready to start, with a team and a sleigh which had a tent over it, and the patient on a bed inside.

On passing my home I was called in to answer the telephone. A boy of four years, living about seven miles down the river, had been playing with a dynamite cap, which exploded and tore his hand, leaving the thumb and little finger dangling with broken bones; the other three fingers blown about the room. I told the mother I would get there as soon as possible and we would have to take the child to a hospital.

The school was handy and the teacher a "brick," so she took her first aid kit over and fixed up the hand. I left my first patient to follow, and as my father had our horse and sleigh ready, away we went as fast as we could, which was not very speedy as the roads were bad. When I got there I re-dressed the hand and telephoned the doctor, resident about twenty miles farther down the river.

The mother was ready and the child wrapped in blankets, who, though having been given an opiate, remained terribly excited and frightened: the wound kept oozing. The mother and I sat in the sleigh and held the child, while a boy drove for us. After driving nine miles we changed to fresh horses and teamster that were ready, but we did not stop to eat, and at 4 p.m. arrived at the doctor's office. I helped him to dress the hand.

The doctor made arrangements by telephone for us to take the child to Grand Falls Hospital, another twenty-eight miles down the river. Assuring us that he would make ar-

Institute of Public Health
Faculty of Public Health of the
University of Western Ontario

rangements with the agent, the doctor advised us to take the fast freight train. We went to the hotel, had supper, and when my other patient from Riley Brook arrived I helped the doctor with him. The station, about two miles below the village, closed early, so away we went and arrived there about 8 p.m.

The man with the horses helped us into the station and departed. I gave the child to the mother and went to the wicket to secure tickets. The doctor had neglected to notify the agent, who said he would have to telephone to Moncton to make reservations, "as it was against the rules and we should have a man with us too." I talked and explained, I was so disappointed. The agent was very kind and sorry. He telegraphed and did the best he could but it seemed hours before he said, "It will be all right." The freight would stop for us. He wanted to help in any way he could, but there was nothing to do but wait so he locked up and went to bed and we were left alone. It was dismal waiting.

When the freight arrived about midnight we went out on the platform but the cars rushed by; we gave up hope of it stopping. I had counted seventy-five cars before it came to a stand still. We got on—the train men were very nice and we arrived at Grand Falls station about 2.30 a.m. Although there was no snow in Grand Falls, on the road to the hospital there were many drifts two feet deep, and the man the doctor had engaged for us had a carriage. It was only a two mile drive but seemed endless. I held the child on my lap while his mother sat beside me. The driver stood behind and we travelled as fast as the horse could go. I breathed a sigh of relief as we drove up to the hospital door. When the nurse came and helped me in with the child the mother turned and fled down the street, I knew not whither.

We were kindly received and after being made comfortable the doctor came and heard my story, then arranged for me to have breakfast while he had his.

By the time the child was ready for the operation, the mother returned. The doctor talked with her and then sent her for a walk.

The child took ether nicely, and it was found necessary to amputate at the wrist. The operating was all over and cleared away by 9 o'clock, the child in bed and doing fine. So we called it a day! His mother and I stayed with him all day and the following night—it helped to keep him quiet.

The stump healed wonderfully, and today he can use it to tie his own shoestrings or in a scrap, to down a boy older and larger than himself.

SUNSHINE TABLE

Gradual Exposure of Baby's Body	Day															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	Number of Minutes															
Hands and Wrists, Feet and Ankles	5	10	15	20	25	30	35	40	45	50	55	60	60	60	60	60
Ankles to Knees	---	5	10	15	20	25	30	35	40	45	50	55	60	60	60	60
Knees to Hips	---	---	5	10	15	20	25	30	35	40	45	50	55	60	60	60
Hips to Chest, front and back	---	---	---	5	10	15	20	25	30	35	40	45	50	55	60	60
Chest to Neck, front and back	---	---	---	---	5	10	15	20	25	30	35	40	45	50	55	60

This Sunshine Table is published by courtesy of the Manitoba Medical Bulletin, October number. Our nurses may find this Table of value to them in directing mothers in the use of sunshine as a means of preserving good health in their young children, especially during the winter months.

News Notes

NEW BRUNSWICK

SAINT JOHN: A well-attended meeting of the Saint John Chapter of the New Brunswick Association of Registered Nurses was held on November 16, when Dr. George F. Skinner gave a much appreciated lecture on Thyroid Glands. Miss E. J. Mitchell, president, was in the chair. Sincere sympathy is extended to Miss Louise Peters on the death of her father.

The Alumnae of Saint John General Hospital met at the Health Centre on December 6, as the Nurses Home was undergoing renovation previous to its reoccupancy by the nurses. During the construction of the new hospital buildings the nurses have resided in the annex for infectious diseases. A letter was received from the Commissioners of the Hospital, who expressed their appreciation and thanks for the Alumnae's gift of five hundred dollars, donated towards the furnishing of free beds in the new buildings. Plans were made for a bridge to be held some time in January.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in December, 1931, were 954, three more than in November, 1931.

APPOINTMENTS

CIVIC HOSPITAL, OTTAWA: Miss Lillian Alkenbrack, 1930, as X-Ray Technician at the Queen Victoria Hospital, North Bay, Ont. Miss E. Gertrude Ferguson, 1930, as Follow-up Supervisor at the Ottawa Civic Hospital. Miss M. L. Luton, 1928, as Assistant Supervisor in the Out-Patient Department of the Ottawa Civic Hospital. Miss Ruth Fraser 1931, Night Supervisor at the Protestant Infants Hospital, Ottawa. Miss Dorothy F. Gorman, 1930, with the Papineauville Health Unit.

DISTRICT 1

VICTORIA HOSPITAL, LONDON: The annual meeting of the Alumnae Association was held at the Gartshore Residence on December 1, when officers were elected for 1931-1932: Hon. President, Miss Hilda Stuart, Superintendent, Victoria Hospital; President, Miss Mae Jones, Windsor and Ridout St., London; First Vice-President, Miss Christena Gillies, Victoria Hospital; Second Vice-President, Miss Margaret McLaughlin, Victoria Hospital; Treasurer, Miss Mildred Thomas, 28 Hayman Court, London; Secretary, Miss Verna Ardiel, 1000 Lorne Ave., London; Corresponding Secretary, Miss Gladys McDougall, 14 Bellevue Ave., London; Board of Directors, Misses Mallock, M. Walker, Mortimer, Mrs. L. McGugan, Mrs. H. Smith, Mrs. Sterritt; Representatives to "The Canadian Nurse," Miss G. Erskine, Victoria Hospital, Mrs. Scanlon, 769 Quebec St.

DISTRICT 2

BRANTFORD: A meeting of the Executive Committee, District No. 2, R.N.A.O., was held at the Victorian Order of Nurses headquarters, Brantford, on November 27. The following attended: Misses A. E. Bingeman, A. S. Weber, Kitchener; Miss M. Davison, Woodstock; Miss M. E. Cade, Tillsonburg; Miss H. Booth. Simcoe; Miss S. M. Jamieson, Galt; Misses H. Kerr, H. D. Muir, J. M. Wilson and Mrs. J. N. Mitchell, Brantford.

The monthly meeting of the Alumnae Association of the Brantford General Hospital was held in the Nurses Residence, December 1st, with twenty-two members present. Following the regular business meeting bridge was played at five tables.

The Brantford General Hospital was a writing centre in connection with the Provincial Registration Examinations, November 25, 26 and 27. Eighteen candidates wrote.

A new feature in the education of the student nurses at the Brantford General Hospital, was the visit of the students studying bacteriology to the water-works to observe the purification of water from the time it leaves the river until it reaches the taps in the homes. Another morning was spent visiting a modern pasteurization plant to study the receiving, testing, pasteurization and transportation of milk. Dr. M. S. Cole, lecturer in Bacteriology, conducted these excursions. The senior class visited the Ontario School for the Blind, Brantford, in connection with their lectures on eye diseases, and after hearing and observing the work done by many blind students, met in the Assembly Hall to study a number of the various types of eye conditions interfering with sight, and to learn a little of the history of each. In addition to being privileged to see these eye cases, one was impressed with the importance of prevention, as well as nursing care, and a third lesson gleaned from this excursion was the stimulus to each one to make the most of their own opportunities, Dr. N. W. Bragg, E.E.N. & T. specialist, conducted this excursion.

Re Red Cross Home Nursing Classes: Miss Nellie Yardley (Brantford General Hospital, 1927) has been appointed local organiser for Brantford and surrounding district. Two classes have already started and are being taught by Miss Dora Arnold and Miss C. Good.

Mrs. J. N. Mitchell, V.O.N., and Miss E. M. McKee, Superintendent, Brantford General Hospital, attended the annual meeting of the Ontario Red Cross in Toronto on Friday, November 27th, 1931.

Mrs. H. P. Plumptre, Toronto, was a recent guest of the Local Council of Women, Brantford, and spoke on the League of

Nations. The following nurses attended: Misses G. V. Westbrooke, J. M. Wilson, L. R. Gillespie, E. M. McKee, Mrs. J. N. Mitchell, Mrs. M. H. MacBride.

The Florence Nightingale Association met in the Nurses Residence, Brantford General Hospital, December 7, for the purpose of making Christmas favours for the ward trays.

Through the generosity of the merchants of Brantford a very excellent Santa Claus parade visited the hospital. The cavalry and the musicians congregated in the courtyard and performed for the children and other patients, while the masqueraders paraded through the hospital distributing goodies to the patients.

General Hospital, Guelph: The Alumnae of the Guelph General Hospital are holding a weekly bridge to aid Miss Ethel Eby, Public Health Nurse, with the city relief milk fund. An operating room note book has been established for the use of the graduate nurses and may be procured at a small fee.

St. Joseph's Hospital, Guelph: A dance was held by the St. Joseph's Alumnae in the Ryan Auditorium, Friday, November 27th, 1931, with a good attendance.

District 4

Hamilton: The quarterly meeting of District 4, R.N.A.O., was held in the Senior Residence of the Hamilton General Hospital on October 17. Miss Anne Wright, chairman, presided. Following the business an interesting address was given by Miss Eileen McGregor, Occupational Therapist at the Mountain Sanatorium. Dr. R. J. Fraser, of the staff of St. Joseph's Hospital, addressed the meeting on "Spinal Anaesthesia," a subject of particular interest to all present.

St. Catherines: The regular monthly meeting of the Mack Training School Alumnae was held at the Leonard Nurses Home with Miss Helen Brown presiding. During the lengthy business session arrangements were made for Christmas cheer and welfare. The Rev. Tuer then spoke on Social Service. The Alumnae Association held a bridge at the Leonard Nurses Home on December 2. The guests were received by Miss Helen Brown, President, and Miss Anne Wright. The committee in charge were: Miss Mildred Strong, Mrs. R. E. Elderkin, Mrs. Charles Hesburn, Mrs. E. Deware and Mrs. Lawrence Hepburn.

District 5

A very successful meeting of District 5, R.N.A.O., was held at the Royal York Hotel, Toronto, on December 3, when one hundred and seventy members sat down to dinner at 7.30 p.m.

With members of the Executive at the head table were the speaker, Dr. John W. S. McCullough, and Mrs. McCullough, Miss Muriel MacKay, Miss Florence Emory, President of the Canadian Nurses Association, and Miss Mary Millman, President of the Registered Nurses Association of Ontario, who were also speakers.

Among the gay groups at small tables were out-of-town members from Collingwood and Oshawa who were motoring back after the meeting.

The Chairman, Miss Rhano Beamish, in her opening remarks referred to the privilege of District 5 in counting as members Miss Emory, President of the C.N.A., and Miss Millman, President of the R.N.A.O., and said that meetings of the district might be termed reunions of the child, the mother and the grandmother.

Miss Emory, leaving it to the membership to decide which was the grandmother, spoke of the Survey of Nursing Education recently completed by Dr. Weir, the report of which will shortly be released from the press. She asked the nurses to approach the study of the report with an open and unprejudiced mind in preparation for discussion of its findings and recommendations at the meeting of the C.N.A. in Saint John, June, 1932.

Miss Millman explained the dependence of the C.N.A. on the Provincial Associations for its membership since abolishing dual membership or membership through Alumnae Associations. Ontario having within its boundaries a larger number of nurses than any other province, had a very definite responsibility in recruiting members and supporting the C.N.A. In referring to the forthcoming report of the Survey, Miss Millman emphasized Miss Emory's appeal for intelligent study of its content. As convener of the programme committee for the annual meeting of the R.N.A.O. to be held in Ottawa during Easter week, Miss Millman gave a brief outline of the sessions when the report of the Survey will be discussed.

Miss Muriel MacKay, of the Hydro-Electric Commission, in her informal and charming way, gave a short history of the development of the work of the Nurse in Industry until the present time, when she holds a strong position in the field of public health.

Miss Ruby Hamilton, Chairman of the Community Health Association of Greater Toronto, introduced Dr. John W. S. McCullough, who, during the past summer travelled in Europe, making a survey for the Provincial Cancer Commission.

Dr. McCullough said he regretted very much being unable to discuss many of the observations and conclusions embodied in the report of the Commission, which is not yet released. But in spite of that he gave a very interesting and practical address from a nurse's point of view. He considers that the nurse has a very definite part to play in a preventive programme in educating the public in regard to early symptoms of cancer.

Miss Rowan moved a vote of thanks, which was heartily endorsed, and brought to a close one of the most enthusiastic meetings of the District.

Toronto: The Board of Directors of the Hillcrest Convalescent Home at 1275 Bathurst St., Toronto, has undertaken a survey of the extent and nature of the need for convalescent care in Toronto. The survey is being carried on in co-operation with a council representing the hospital and community interests. Its purpose is three-fold: (1) to study the nature and extent of the

community need; (2) to study the use of existing resources and facilities; (3) to present the conclusions of the study to the community. Miss Laura A. Gamble, Reg.N., has been appointed director of the survey. Miss Gamble's office is at 1275 Bathurst St., Toronto.

WOMEN'S COLLEGE HOSPITAL, TORONTO: The annual election of officers was held at the Grenville Street Clinic on November 9. Miss Henry was given the chair by acclamation. It was decided that the Alumnae should hold a shower on December 14 for the Christmas Tree in aid of the Clinic. On November 28 the Alumnae held an enjoyable bridge party (32 tables) at the King Edward Hotel. Miss Meiklejohn, assisted by Miss Avery, received the guests. The success of the afternoon was due to the untiring efforts of Misses Fraser, M. Shaw, Dunning and Varey.

HOSPITAL FOR SICK CHILDREN, TORONTO: The December meeting of the Alumnae took place in the Nurses Residence on December 10. There was a large attendance and all came with generous armfuls of parcels for the Good Cheer baskets which were being packed by the Welfare Auxiliary. A very fine programme of Christmas music, readings and contests were given, and a delightful social "get-together" was enjoyed by everyone.

Dr. and Mrs. D. T. Kendrick (Irene Newcombe, Hospital for Sick Children, 1928) have returned to Toronto to reside. Miss Helen Boothe (1926), Miss Doris Bews (1928), and Miss Marjorie Henderson (1928), are attending the post-graduate course at the Mothercraft Centre, Toronto. Miss Jean Maston (1920) is in the operating room at the Pavilion at Toronto General Hospital. Mrs. Dunham is on the staff at the Preventorium Hospital. Sincerest sympathy is extended to Miss Reba Simpson in her recent bereavement.

DISTRICT 6

District No. 6, R.N.A.O., held its annual meeting in Port Hope Hospital, October 27, at 2.30 p.m. Thirty-five nurses, representatives from Port Hope, Coburg, Bowmanville, Lindsay, Fenelon Falls and Peterboro were present, with Miss R. Bell in the chair. The following officers were elected for 1932: Chairman, Miss R. Bell, General Hospital; Port Hope; Vice-Chairman, Miss Graham, Coburg; Secretary-Treasurer, Miss L. Simmons, Peterboro; Private Duty Section, Miss M. Watson, Peterboro; Public Health Section, Miss McKenzie, Lindsay; Nursing Education, Section, Mrs. Leeson, Nicholls Hospital, Peterboro; Convener Membership Committee, Miss Helen Anderson, Peterboro; Councillors, Miss F. Dixon, Peterboro; Miss Morrison, Lindsay; Miss Elliott, Port Hope; Mrs. Smythe, Bowmanville; Miss McIndoo, Belleville; Miss L. Gaden, Prince Edward County Hospital, Picton; Representative to "The Canadian Nurse," Miss E. Walsh, Nicholls Hospital, Peterboro.

The report of the committee on organisation of chapters within the district was read by Miss Dixon, Peterboro, and recommended the division into chapters as follows: (A) Prince Edward County and Hastings; (B) Northumberland and Durham; (C) Peterboro, Victoria and Haliburton. The committee recommended further that the district should elect to its executive two councillors from each chapter, and that these councillors should become chairman and vice-chairman of the chapter; that other officers of the chapter should be secretary-treasurer, convener of membership, and a councillor for each section. The committee wish it definitely understood that all members of chapters must be members of the R.N.A.O.

The following officers were elected for the chapters:

Chapter A (Prince Edward County and Hastings): Councillors, Miss McIndoo, Belleville; Miss Gaden, Prince Edward County Hospital, Picton. Convener of Nominating Committee, Miss Collier, Belleville.

Chapter B (Northumberland and Durham): Councillors, Miss Elliott, Port Hope; Mrs. Smythe, Bowmanville. Convener of Nominating Committee, Miss Rundle, Bowmanville.

Chapter C (Peterboro, Victoria and Haliburton): Councillors, Miss Dixon, Peterboro; Miss Morrison, Lindsay. Convener of Nominating Committee, Miss Reid, Lindsay.

A motion was passed that each chapter should raise money for a bank account and send local news items to Miss Walsh, publications convener for the district, before the fifth of each month, for publication in "The Canadian Nurse".

It was decided to hold the district meeting once a year. The meeting adjourned for tea, after which Dr. Stewart Cameron, Peterboro, gave a very interesting address on "The Survey of Nursing Education in Canada". Miss Dixon, seconded by Miss Watson, moved a vote of thanks to Dr. Cameron and also to Miss Elliott, Port Hope Hospital.

BELLEVILLE: The opening meeting of Belleville General Hospital Alumnae for the year 1931 and 1932 was held on October 6. A large number were present. Officers were elected for the year and tea was served at the close of the business meeting.

Miss Margaret Tait, former Superintendent of Belleville General Hospital, recently visited the city and received a warm welcome from the graduate nurses.

PETERBORO: A meeting for the reorganisation of Chapter C of District 6, R.N.A.O., was held at the Nurses Residence, Nicholls Hospital, Peterboro, on November 24, 1931, at 3 p.m., with a fair attendance. The following officers were elected: Chairman, Miss Dixon, Peterboro; Vice Chairman, Miss Morrison, Lindsay; Secretary-Treasurer, Miss Alice Price; Nursing Education Councillor, Miss Reid, Lindsay; Private Duty Councillor,

Mrs. La Plante; Public Health Councillor, Miss Jory; Convener of Membership, Miss McKinnon; Convener of Publication, Miss Edna Dawson; Convener of Programme Committee, Miss Simmons. It was decided that meetings be held in the evening, the first to be held in January, and that the membership fee be 25 cents.

The Nicholls Hospital Alumnae held their annual banquet on December 3. About seventy nurses assembled with a large number of guest nurses, graduates of other hospitals. The speaker of the evening, Rev. Dr. McLean, gave a very pleasing address. The toast proposed to The Guests by Miss Walsh was responded to by Miss Simmons. The toast to the Old and New Graduates by Miss McBrien was responded to by Miss Anderson, president of the Alumnae. The toast to "The Alma Mater" by Miss Smith, was responded to by Mrs. Leeson, Superintendent. Miss Dixon, past president of the Alumnae, gave a very instructive talk on organising a chapter for the district. An enjoyable dinner was brought to a close by singing of "Auld Lang Syne".

DISTRICT 8

Members of District No. 8, R.N.A.O., held an interesting meeting on November 4 at the Royal Ottawa Sanatorium. One hundred and nineteen members attended. Miss Dorothy Percy presided in the absence of the Chairman, Miss Alice Ahern. The members listened to an excellent address on "Modern Treatment of Tuberculosis" by Dr. D. A. Carmichael. A symposium on Tuberculosis was given (1) by Miss Jean Church on "Responsibility of Private Duty Nurse in Tuberculosis"; (2) by Miss Marjorie Robertson, who gave a paper on "Public Health Work in Tuberculosis Nursing"; and (3) by Miss Mabel M. Stewart who spoke on "The Role and Opportunities of the Institutional Nurse in Tuberculosis Nursing". Dr. R. E. Wodehouse, Secretary of the Anti-Tuberculosis Association, gave a very interesting address on "Sanatorium Ecomonics and Diagnostic Service".

Misses Helen Smith, Ida McDowell, Jean Forbes and Lillian Garrett of the Ottawa Civic Hospital, are at present attending McGill University.

GENERAL HOSPITAL, OTTAWA: Under patronage of Mayor Allen of Ottawa and Mrs. Allen, the Nurses Alumnae of the Ottawa General Hospital held a charmingly arranged supper dance at the Chateau Laurier on November 18. This event, attended by more than four hundred people, was most enjoyable. The hostesses of the evening were Lady Clark, wife of the High Commissioner of Great Britain, Mrs. L. Arthur Cannon, Mrs. J. J. Allen, Mrs. F. P. Quinn, Miss Juliette Robert, president of the Alumnae, and Miss Munro, convener of the dance committee.

QUEBEC

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: The monthly meeting of the Alumnae Association was held at the Hospital. Dr. H. S. Mitchell, Medical Superintendent, gave a most interesting talk on "Poliomyelitis" and demonstrated the uses of the new "Respirator". Miss Muriel Bazin, of the Hospital for Sick Children, Toronto, has joined the staff. Miss Alice Bell has resigned from the staff and is doing special duty. Miss Margaret Watson visited the hospital recently. It was with much sorrow that the members of the Alumnae Association learned of the death of Dr. Walcot, of Lachine. Deepest sympathy is extended to Mrs. Walcot (S. Bishop, Children's Memorial Hospital, 1912) and family.

ROYAL VICTORIA HOSPITAL, MONTREAL: Miss Rae Fellowes, 1928, is now with the Social Service Department of the Royal Victoria Hospital. Miss Winnifred Wallace, 1918, has accepted the position of Assistant Superintendent of the Harbour Hospital, New York. Miss May Kinder, 1925, has resigned from the staff and has been succeeded by Miss Anna MacLeod, 1930.

WESTERN HOSPITAL, MONTREAL: The sympathy of the Alumnae Association is extended to Miss Olga McCrudden on the death of her aunt, Mrs. McNaughton. Recently Miss Freda Jawes (1924) paid the hospital a short visit. Miss M. Munro (1905) is now living in Kelowna, B.C. Miss Hilda Marjorie Smith, Trinidad, is taking a course in Public Health in England.

SHERBROOKE: On November 16 and 17 an Institute was held at the St. Vincent de Paul Hospital for Metropolitan nurses in individual districts in the Province of Quebec. Miss Alice Ahern, Assistant Superintendent of Nursing, presided. Others present were Miss M. Taschereau, Metropolitan Supervisor in charge of the Frontenac Office in Montreal, Miss J. Gauthier, nurse in charge of the Practice Centre, Miss H. Dupuis, Pre-natal Supervisor, and representatives of the local Medical Association, Victorian Order of Nurses, l'Assistance Maternelle and Child Welfare League. The Institute was most successful. The nurses were deeply interested and enthusiastic and felt that the various lectures and demonstrations and the contacts made had been very profitable.

GENERAL HOSPITAL, MONTREAL: Miss Edythe Ward (1923) is night supervisor and Miss Edith McQuisten (1925) is on floor duty at The Women's General Hospital, Montreal. Miss Louise Foss (1928) has taken a position in a doctor's office. Miss Margaret Campbell (1929) is relieving in the Social Service Department, Montreal General Hospital. The sympathy of the Association is extended to Miss Lucy White on the death of her father.

SASKATCHEWAN

MOOSE JAW: The graduates of the General Hospital have formed an Alumnae Association: Honorary Member, Mrs. M. A. Young, Superintendent; President, Miss L. Carter; Vice-President, Mrs. M. Fitzgerald; Secretary, Miss A. Cheavins; Corresponding Secretary, Miss E. Heglin; Treasurer, Miss G. Winsor.

Institute of Public Health
Faculty of Medicine
University of Western Ontario
LONDON CANADA

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BADGELY—On September 22, 1931, at Detroit, Mich., to Dr. and Mrs. Carl E. Badgely (Florence Chandler, Sarnia General Hospital, 1919), a daughter.

BROWN—On October 29, 1931, at Sarnia, Ont., to Mr. and Mrs. Gordon Brown, Brigden, Ont. (Margaret Noble, Sarnia General Hospital, 1919), a daughter.

CHALMERS — Recently, at Somerset, Man., to Mr. and Mrs. W. E. Chalmers (Mabel Horn, Winnipeg General Hospital, 1921), a daughter.

CHESLEY—On November 3, 1931, at Saint John, N.B., to Dr. and Mrs. Arthur Chesley (Beatrice Reed, Saint John General Hospital), a son.

DODDS—On November 8, 1931, to Mr. and Mrs. Wm. Dodds (Brenda Farmer, Winnipeg General Hospital, 1925), a daughter.

ELLIS—On November 1, 1931, at Saint John, N.B., to Mr. and Mrs. Harvey Ellis (Muriel Purdy, Saint John General Hospital, 1925), a son.

FRASER—On September 22, 1931, at Hamilton, to Dr. and Mrs. Fraser (Mildred Currie, St. Joseph's Hospital), a son.

GRAY—In September, 1931, at Hanover, Ont., to Mr. and Mrs. Euert Gray (Mary Clarke, Guelph General Hospital, 1927), a son.

HARPER—On November 26, 1931, at Vancouver, B.C., to Mr. and Mrs. William Harper (Florence Wray, Vancouver General Hospital), a daughter.

JACKS—On November 17, 1931, at Hamilton, to Mr. and Mrs. W. O. Jacks (Isobel Goodfellow, Hamilton General Hospital, 1930), a son (William John).

LEE—On November 2, 1931, at Vancouver, B.C., to Mr. and Mrs. William C. Lee (Dorothy Graham, Vancouver General Hospital), a son.

LOUGHEED—On November 24, 1931, at Hamilton, to Mr. and Mrs. John Lougheed (Susan Ramsay, Hamilton General Hospital, 1929), a daughter (Jacqueline Isabel).

MASON—On November 1, 1931, at Winnipeg, to Mr. and Mrs. Mason (A. Pilgrim, Winnipeg General Hospital, 1930), a son.

McLEAN—On November 22, 1931, at New Orleans, Louisiana, to Dr. and Mrs. Bazil McLean (Carrie Davis, Montreal General Hospital, 1920), a son.

MacMILLAN—On October 14, 1931, at Vancouver, B.C., to Mr. and Mrs. Hugh MacMillan (Dorothy Hall, Vancouver General Hospital), a daughter.

MERRITT—On November 9, 1931, at Winnipeg, to Dr. and Mrs. Paul Merritt (Violet Neelin, Winnipeg General Hospital, 1928), a daughter.

MOODIE—On October 13, 1931, at Kitchener, to Mr. and Mrs. Moodie (Rose Schmalz, St. Joseph's Hospital, Hamilton, 1925), a son.

MOORE—One June 18, 1931, at Waltham, Mass., to Dr. and Mrs. Clifford D. Moore (Alfreda M. Morley, Kingston General Hospital, 1928), a son (Clifford Douglas).

STEVENS—On September 12, 1931, at McKay Memorial Hospital, Taihaku, Formosa, Japan, to Dr. and Mrs. Eugene Stevens (Queenie Harris, Victoria Hospital, London, 1928), a son (Robert Eugene).

WARICK—On November 7, 1931, at Winnipeg, to Mr. and Mrs. A. H. Warick (Kay Yellowlees, Winnipeg General Hospital, 1930), a son.

WHITE—In October, 1931, at Sudbury, Ont., to Mr. and Mrs. R. B. White (Olive Dawson, Nicholls Hospital, Peterboro, 1926), a daughter.

WILSON—On September 2, 1931, at St. Catharines, to Mr. and Mrs. M. Wilson (Anna Gayman, St. Catharines General Hospital, 1927), a daughter (Barbara Marie).

WOODS—On November 20, 1931, at Vancouver, B.C., to Mr. and Mrs. F. G. C. Wood (Beatrice Fordham Johnson), a daughter.

ZERON—On August 11, 1931, at Faron's Point, Ont., to Mr. and Mrs. Wilfred Zeron (Alice Ford, Toronto Western Hospital, 1919), twin girls.

MARRIAGES

ALBRIGHT—GRAY—On August 13, 1931, at Cleveland, Ohio, Vera Gray (St. Joseph's Hospital, Hamilton, 1925), to G. Albright, of Cleveland.

ANDREWS—SIMPSON — On September 12, 1931, at Lonsdale, Ont., Miss G. Simpson (Belleville General Hospital), to Mr. J. Andrews, of Belleville, Ont.

ANNABLE—BELFORD — On November 28, 1931, at Ottawa, Garuer L. Belford (Montreal General Hospital, 1926), to H. R. Annable, of Montreal.

BAUMAN—GRAHAM — On August 25, 1931, at Westmeath, Edna Marion Graham (Ottawa Civic Hospital, 1931), to Bert Eric Bauman, of Arvida, P.Q.

BENNETT—FAULKNER—On September 5, 1931, at Port Dover, Ont., Helen Faulkner (Hamilton General Hospital, 1926), to William Roy Bennett, of Toronto.

BLACK—EARLE—On November 14, 1931, at Brockville, Ont., A. B. Earle (Belleville General Hospital), to S. Black, of Huffs Island, Ont.

BROWN—EMERSON—On November 21, 1931, at Caledonia, Ont., Annie Emerson (Hamilton General Hospital, 1929), to Frederick Brown.

BURN—MONTGOMERY — On September 5, 1931, at Montreal, Jean Montgomery (Royal Victoria Hospital, 1929), to Grant Burn.

CAMPBELL—MALLABY—On November 21, 1931, at Toronto, Rhoda Mallaby (Grace Hospital, Toronto, 1924), to George Herbert Campbell.

COATES—HOUGH — On November 14, 1931, Annabelle Hough (Brantford General Hospital, 1922), to Dr. L. H. Coates, Brantford. Dr. and Mrs. Coates will reside at 133 Brant Avenue, Brantford.

CHRISTIE—SMITH — On October 17, 1931, at Lachute, Que., Doris Smith (Homoepathic Hospital, Montreal, 1923), to J. Keith Christie, of Lachute. Residing in Montreal.

COTES—STEVEN — On September 23, 1931, at Chicago, Grace E. Steven (Regina General Hospital, 1916), to Monroe E. Cotes. At home 2628 Burling Street, Chicago.

FARMER—SCOTT—At Toronto, Luella Scott (Toronto General Hospital, 1930), to Dr. Alfred Farmer.

GRIFFIN—COATES—Recently, at Oliver, B.C., Helen Jean Coates (Hospital for Sick Children, 1928), to Benjamin Griffin, of Oliver, B.C.

HAMILTON—GUGIN — On August 22, 1931, at Minnedosa, Man., Helen Gugin (Winnipeg General Hospital, 1929), to John Hamilton, of Winnipeg.

HALL—WHYTE—On September 12, 1931, at Montreal, Elizabeth Whyte (Royal Victoria Hospital, 1928), to T. Hall.

HAMILTON—KEFFER—On November 7, 1931, at Brantford, Florence W. Keffer (Brantford General Hospital, 1928), to Reginald H. Hamilton.

HARRIS—DOUQUETTE—At Ottawa recently, Ruth Marguerite Duquette (Ottawa Civic Hospital, 1929), to Frederick Seymour Harris, of Ottawa.

HILYER—REID—On November 14, 1931, at Toronto, Agnes Josephine Reid (Grace Hospital, Toronto, 1920), to Clarence H. Hilyer.

HOPPER—DILLABOGH — In August, 1931, Velma Clarissa Dillabogh (Ottawa Civic Hospital, 1929), to Charles Watson Hopper, of Westboro.

HOWLETT—CHISHOLM — On November 21, 1931, at Montreal, Beryl M. Chisholm (Montreal General Hospital, 1929), to Dr. Leslie E. Howlett, of Ottawa.

HUTCHINSON—ARMSTRONG—On October 12, 1931, at Bailieboro, Isobel Armstrong (Nicholls Hospital, Peterboro, 1925), to William Hutchinson.

JOHNSTON—RICHARDSON — On September 26, 1931, at Queensville, Ont., Priscilla Viola Richardson (Toronto Western Hospital, 1927), to Dr. Cameron L. Johnston.

KNEIRMIER—KELLY—On August 24, 1931, at Hamilton, Ethel Kelly (St. Joseph's Hospital, Hamilton), to Matthew Kneirmier, of New York City.

KNIFFEN—BURRILL—On September 29, 1931, in Montreal, Marjorie Jean Burrill (Homoepathic Hospital of Montreal, 1930), to Leslie Kniffen. Residing in Montreal.

LAMBERTS—CUMMERFORD — On September 5, 1931, at Thorald, Adelaid Cummerford (St. Joseph's Hospital, Hamilton, 1928), to Gordon Lamberts, of Walkerton, Ont.

LAMONT—REED — On August 4, 1931, at Ottawa, Gladys Maude Reed (Lady Stanley Institute), to Sergt. Hugh McKirdy Lamont, of the Canadian Legation, Washington.

LENEY—STEEL—At Montreal recently, Florence Steel (Royal Victoria Hospital, 1922), to W. Leney.

LESTER—BYRNES—On July 29, 1931, at Guelph, Laura Byrnes (St. Joseph's Hospital, Hamilton, 1930), to Call Lester, of Guelph, Ont.

LINDSAY—CARRUTHERS — On August 28, 1931, at Inglewood, N.J., Alma Irene Carruthers (Victoria Hospital, London, 1929), to Dr. Kenneth Lindsay, of Buffalo, N.Y.

MARSHALL—AULT — On August 18, 1931, at Brinston, Ont., Beulah Ault (Brockville General Hospital, 1929), to William Marshall, South Mountain, Ont.

McCOLLUM—BALLAGH — Recently at Teeswater, Jessie Ballagh (Hospital for Sick Children, 1928), to Dr. Hugh McCollum, of London, Ont. Dr. and Mrs. McCollum have taken up residence at Teeswater.

McKINNEY—McMANN — On November 14, 1931, at Cold Springs, Ont., Lilly Irene McMann (Grace Hospital, Toronto, 1930), to Dr. John Henry McKinney, of Brooklin, Ont.

McMACKLIN—CROCKETT—On November 7, 1931, in Saint John, N.B., Margaret Crockett (Saint John General Hospital, 1931), to Edward McMacklin.

MELDRUM—PLACE—On September 5, 1931, at Prescott, Ont., Alda Eunice Place (Ottawa Civic Hospital, 1927), to Lorne Alexander Meldrum, of Ottawa

MONYPENNY—CLARK—On October 28, 1931, at Toronto, Vera Madeline Clark (Toronto General Hospital, 1928), to Arthur Douglas Monypenny.

NORMAN—DEVINE — On October 28, 1931, at Toronto, Coral M. Devine (Toronto Western Hospital, 1929), to Alfred W. Norman. At home, 530 Strathmore Blvd., Toronto.

NESBITT—LAWFORD—On September 3, 1931, at Winnipeg, Flora Lawford (Winnipeg General Hospital, 1906), to N. L. Nesbitt, of Chicago, Ill.

PARMALEE—STITT—On September 12, 1931, at Fort Coulonge, P.Q., Lillas Stitt (Ottawa Civic Hospital, 1926), to Wilfred Alexander Parmalee, of Ottawa.

SAMPLE—GIBSON—On October 16, 1931, at Sarnia, Ont., Margaret J. Gibson (Public General Hospital, Chatham, 1930), to Clarence Sample, of Chatham, Ont.

SCANLON—MURRAY—On December 5, 1931, at Vancouver, B.C., Alfreda Murray (Vancouver General Hospital), to Robert H. Scanlon, of Powell River, B.C.

SKARRETT—WOOD—In November, 1931, at Guelph, Ont., Olive Wood (Guelph General Hospital, 1931), to Clyde Skarrett, Sarnia.

STAHL—GRAHAM—On October 5, 1931, at Alliston, Ont., Doris A. Graham (Toronto Western Hospital, 1929), to Dr. Oscar Stahl, of Timmins, Ont.

WEDLOCK — ADAMS — In September, 1931, at Peterboro, Ont., Daisy Adams (Nicholls Hospital, Peterboro, 1926), to William Wedlock.

WELCH—PEAT—On November 21, 1931, in Edmonton, Alta., Louise B. Peat (Toronto Western Hospital, 1916, also of the C.A.M.C.), to Gilbert W. Welch, of Port Rush, Ireland.

DEATHS

AIKMAN—On December 3, 1931, at Winnipeg, after a lengthy illness, Elizabeth Ramsey Aikman (Winnipeg General Hospital, 1912, and British Red Cross and Canadian Army Medical Corps Nursing Service, 1914-1918).

DeVOIN—Suddenly, on November 20, 1931, at Smithers, B.C., Mrs. DeVoin, formerly Nursing Sister Gertrude Everleight.

LOUCKS—On November 29, 1931, at Montreal, Mrs. Loucks (Lyle Weston, Montreal General Hospital, 1895).

THE CANADIAN NURSE

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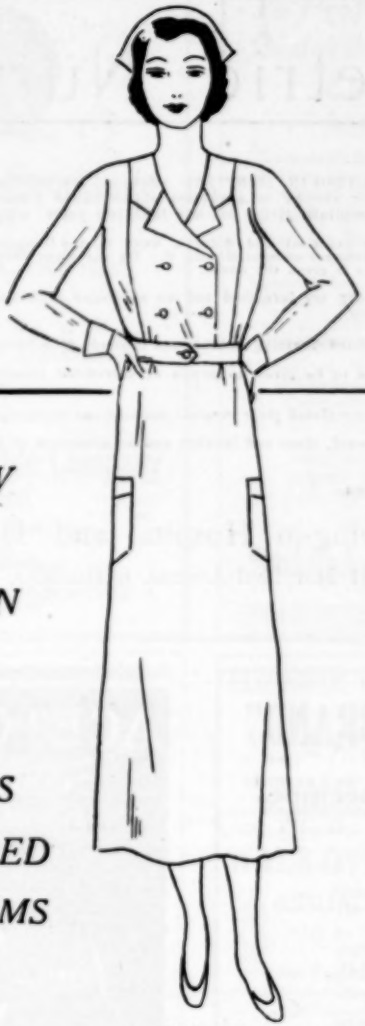

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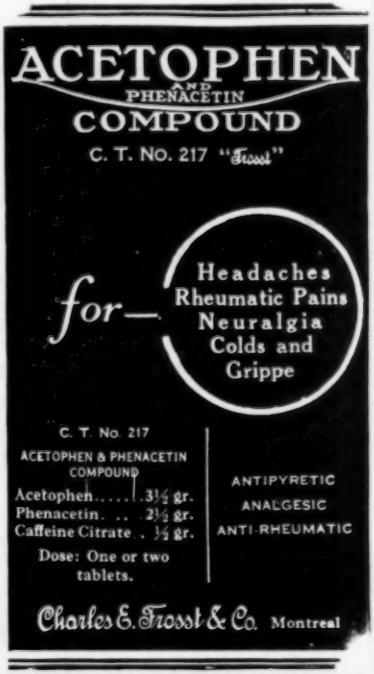

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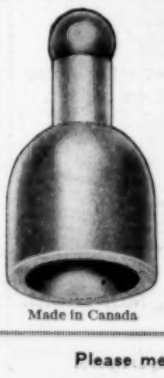
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